



ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

ASSESSMENT OF UTILIZATION AND FACTORS OF SKILLED BIRTH ATTENDANCE AMONG WOMEN OF CHILDBEARING AGE IN ANKASHA GUAGUSA WOREDA, AWI ZONE, AMHARA REGIONAL STATE, NORTHWEST ETHIOPIA.

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Assessment of Utilization and Factors of Skilled Birth Attendance among Women of Childbearing Age in Ankasha Guagusa Woreda, Awi Zone, Amhara Regional State, Northwest Ethiopia, 2014

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LIST OF ACRONYMS

AAU:	Addis Ababa University
ANC:	Antenatal Care
AOR:	Adjusted odds ratio
COR:	Crude odds ratio
CI:	Confidence Interval
CSA:	Central Statistics Agency
DHS:	Demographic and Health Survey
EOC:	Emergency Obstetric Care
HSEW:	Health Services Extension Workers
HF:	Health Facility
IMCC:	International Mother and Child Care
IDI:	In-Depth Interview
MCH:	Maternal and Child Health
MDGs:	Millennium Development Goals
MMR:	Maternal Mortality Ratio
MS word:	Micro Soft Word
PID:	Pelvic Inflammatory Disease
SPSS:	Statistical Package for Social Sciences
TBA:	Traditional Birth Attendance
UNFPA:	United Nation Population Fund
WHO:	World Health Organization

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ABSTRACT

Introduction; The Ethiopian Demographic and Health Survey in 2011 reported maternal mortality ratio of 676 maternal deaths per 100,000 live births which made our country among the 10 highest contributors' of maternal death. Many Thesis results showed that properly equipped and supported skilled birth attendance reduce many of these complications. However, only 11.5 % of Ethiopian mothers were supported by skilled birth attendant during their labour and delivery.

Objective: - To assess prevalence and factors to utilize skilled birth attendants among mothers who gave birth during the last one year in Ankasha Guagusa district.

Methods: - A mixed study design employing a cross sectional household survey with in-depth interview and focus group discussion were employed. A total of 373 women age 15 to 49 years who gave birth in the past one year were asked. The sample size for the qualitative method was determined by saturation of ideas. Descriptive summary measures and associations between the various factors with skilled birth attendance were done employing Binary and Multivariate Logistic Regression. Thematic analysis was also used for the qualitative study.

Result-

The study showed that the prevalence of skilled birth attendance utilization among women who gave birth for the last one year in the study area were 70(18.8%). Main determinant factors associated to low utilization of skilled birth attendance in the study district were; women residence, educational status, ANC visit, type of health facility near to them, problem during labour and respondent's attitude towards pregnancy and labour service. The odds of skilled birth attendance utilization among urbanites were AOR=5.5:195%CI (2.23, 13.57), educational status 2nd and above AOR=6.27 :(1.31, 30.05), numbers of ANC visit 4th and above AOR=12.96:95%CI (3.20, 52.51) and women who encountered complications during their labour AOR=61.97:95%CI (19.83, 193.65) times higher than those counterparts. On the contrary mothers reside near to health post and unfavourable attitude of mothers towards maternal health care services were 83% and 65% less likely assisted by skilled birth professionals during their delivery than those the opposite parts respectively. Moreover, cultural practices, beliefs and barriers were other concomitant factors for low utilization of skilled birth attendance.

Conclusion

Skilled birth attendance utilization in the study area was very low due to different barriers. Hence, to bridge this gap especially women's educational and awareness towards maternal health care services and cultural influences; sustainable awareness should be created by designing appropriate strategies including provision of targeted information, education and communication and integration among health care providers and other stakeholder at the community and health facilities.

Key-words - Home delivery, skilled birth assistant, skilled birth attendance.

1. INTRODUCTION

1.1 Backgrounds

Even though pregnancy and childbirth is a natural phenomenon and often eventful processes which most women aspires to some point in their lives, this normal life affirming process carries its serious risk and complications to both the mother and baby(1, 2). More than half a million with age 15 to 49 years of women die every year of causes related to pregnancy, labor and child birth(3). Over 99% of these deaths occur in Sub-Saharan Africa (SSA). Reports show that more than 75% of maternal deaths are easily preventable and avoidable of direct obstetric causes such as haemorrhage, sepsis, abortion, and ruptured uterus and hypertensive diseases of pregnancy(1, 2).

To decrease maternal morbidity and mortality globally, world leaders started to join their efforts together at the dawn of the millennium by the MDG through the safe motherhood initiative(4). Targets were set at the International Conference on Population and Development+5 (ICPD+5) to have more than 80% of deliveries assisted by skilled birth attendants globally by 2005, 85% by 2010 and 90% by 2015(5). Studies from both industrialized and developing countries indicate that maternal mortality is generally lower in countries where a higher proportion of deliveries are conducted by skilled attendants(5). WHO has defined a skilled attendant as –an accredited health professional-such a midwife, doctor, or nurse-who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns(6). Based on the information currently available at hand, experts and higher officials agree that skilled care should be a central element of any program and strategies that aims to reduce maternal deaths(4). That is why world leaders gave a central place to maternal health and gender equality in the Millennium Development Goals. MDG 5, Improving Maternal Health, is often called “the heart of the MDGs”(7, 8)

1.2 Statements of the Problem

Globally over 500,000 women die every year from pregnancy and childbirth complications and 300 million women suffer with debilitating injuries, often with lifelong consequences. More than 70% of maternal deaths are attributable from five major complications, and 77% occur during or soon after childbirth (within 24 hours)(3). The lifetime risk of death due to pregnancy-related complications is 250-fold higher among women in developing than in developed countries(9). In Ethiopia rates of maternal and child mortality are among the highest in the world with current estimate of MMR being 676 deaths per 100,000 live births or approximately 7 deaths per 1000 live births and under five mortality rate of 88 deaths per 1,000 live births according to EDHS 2011(8).

The Federal Democratic Ethiopia Ministry of Health has a goal of reducing maternal mortality by 75 percent and at least 60% of births assisted by a skilled birth attendant by 2015 and which has been adopted as an international development target as part of the Millennium Development Goals(8). It is amazing to note that in spite of all previous national and global efforts, the Maternal and Newborn morbidity/mortality indices have shown no change and/or only marginal reductions in the last five years, making the MDGs targets by 2015 clearly unachievable using current strategies alone(10). Possible reasons for poor health outcomes among women and newborn is non-use of modern health care services by sizable proportion of women and little knowledge about the current magnitude and factors influencing the use of these services in Ethiopia(11-13).

Studies conducted in different parts of Ethiopia have shown that no one factor influence skilled attendance, but group of factors could account for the problem. It is observed that socio-cultural, economic and geographical circumstances and quality of health care services among others are responsible for low coverage of professionally attended deliveries(14-16).

Similar to other regions of our country the Amhara region including Awi zone skilled birth attendance utilization is still low 10.1%(8). Even if there was no community based study done in Ankasha Guagusa Woreda of Awi Zone, according to 2013 woreda report one year administrative coverage of skill delivery of the Ankasha Guagusa woreda was still low 21.7%(17). Therefore, the study will be very crucial to identify those factors affecting utilization of safe delivery service in the studying area.

1.3 Rationale of the Study

Maintaining the general health condition of the mothers during labor, delivery and postpartum will have a great effect for all family, community in general as well as the economic and social wellbeing of the country. However, in most developing countries the overall status of women's has not been that much changed. In spite of the fact that maternal health service utilization is the key factor to improve the maternal health, but little is known about the current magnitude of use and factors influencing the use of these services in Amhara Region. Moreover, there were no rigorous researches done on the issue under caption in Ankasha woreda of Awi zone. Therefore, this research, aimed at exploring prevalence, factors, personnel and community barriers which are responsible for low delivery care by skilled attendant of women who give birth for the last one year in the study district. The result of this study will give information for program planners, heads of the Zonal and Woreda health offices and health care providers to assure reproductive health strategy that focuses on maternal health, the need to empower women, men families and communities to recognize pregnancy delivery related risks. Moreover it provides information by forwarding possible remedies based on identified factors that influence skilled birth attendance utilization in the study area(8)

2. LITRATURE REVIEW

2.1 Magnitude of Skilled Delivery Attendance

Globally, only 63% of deliveries are assisted by skilled attendants, and 40% of births take place in health facility(3). Research done in different parts of African countries like Tanzania, Rwanda, and Nigeria despite the high coverage of ANC attendance and free maternal health care services, the proportion of births delivered at home or delivery without professional assistance is higher than those mothers who delivered in health facility and is assisted by skilled birth attendant during delivery or few incremental changes in number seen in the last two decades(13, 18).

Similarly, when we reviewed national studies like Ethiopian Demographic Health Survey (DHS), major gaps were identified as the trends on two rounds in 2005 and 2011 more than 90 % of mothers delivered without the assistance of trained health personnel's in their home but the proportion of births assisted by skilled health professionals were 6% and 10% respectively(8). Institutional delivery is very low in Ethiopia. survey done in 4 regions of Ethiopia by Jones Snow Incorporated-Last Ten Kilometers (JSI-L10K) in 2008-09 result showed that most of the childbirths took place at home (91%) which could not be attended by skilled birth attendants; 9% of them were attended by health professionals(8, 13). Similarly Studies conducted in rural Butajira and Admitulu revealed that 88% and 83% mothers preferred to give birth at home(8).

2.2 Barriers on Skilled Delivery Attendance

2.2.1 Personal Factors

2.2.1.1 Socio Demographic and Economic Factors

A number of studies identified socio economic and demographic factors influencing the utilization of skilled birth attendant during delivery. For instance, studies done in different parts of Asia and Africa like Afghanistan, Rwanda, Ghana, and Kenya showed that socio-economic factors like family size and health covariates were strongly affected by the utilization of skilled professionals at delivery and more institutional delivery users were among urban dwellers than rural; mothers with low family size than high family(13, 19-21). The educational status of the women and that of their partners had strong relationship with the choice of delivery place.

Educated women presumably have better sense of appreciation and concern for their health. The study conducted in Tigray showed that mothers who had educated family members were positively influenced to select health facility as a delivery place. Similarly, results from studies done in different regions of Ethiopia also showed similar conclusions (12, 13, 16, 22).

2.2.1.2 Obstetric Factors

Many studies confirmed that mothers who had lower age at first pregnancy and previous use of professionally assisted delivery are commonly found to be significantly associated with safe delivery service utilization (21, 23, 24). Particularly, antenatal care given to pregnant mothers has been found to have strong positive correlation with institutional delivery. A study in India showed that women with a relatively high level of antenatal care had almost four times higher odds of using trained assistance at delivery than women with a low level of care(24).

Population-based survey which was done in rural Cambodia showed that women who had experienced prolonged labor and frequent antenatal care attendance was a significant determinant of facility delivery i.e. once a woman has delivered with the aid of an unskilled attendant, she is five to seven times less likely to seek skilled assistance than a primiparous(9). In Ethiopia, the nationwide DHS indicated that delivery in a health facility is more common among mothers who had at least 4 antenatal visits(8). Maternal parity is the main predictor of utilization of delivery care services in rural Ethiopia(20, 25). Women with 2-4 and 5+ children are 60 percent and 50 percent respectively less likely to receive delivery care than parity one women(20, 25).

Decision Making Power

The various dimensions of autonomy, such as position in the household, financial independence, mobility and decision-making power regarding one's own healthcare, may all impact on health seeking behaviour(21, 26, 27). In Bangladesh, a community based survey showed that women's access to preventive and curative care is very low. Majority of women especially those living in developing countries are economically dependent on their husbands who may be unwilling to pay for services

and transport to get medical care; moreover, cultural and social norms restrict women's mobility and prevent them from seeking health care(23).

In many conservative communities of Bangladesh, gender inequality expressed not only in the form of disempowerment and low social status but also women's and girls' limited access to education deprives them of the knowledge and tools to make informed health decisions(23). Similarly, in Indonesia women's who had no stake in the household assets were found to be at a disadvantage in terms of health care decision making to use ANC and delivery attendant at birth than those women's who had owing assets(26).

In many parts of the developing World including Ethiopia, women's power to make decisions is limited, even over matters directly related to their own health as mentioned by different research articles(2, 14, 16, 28). In a community based and prospective cross sectional studies done in Jimma Town, Oromiya region and North Gondar Zone, Amhara region indicated that women's autonomy, household wealth and decision making power about getting institutional delivery service had significant difference between who delivered in HFs and those who delivered at home. Women, who can decide by themselves to get Institutional Delivery services, are 3 times more likely to deliver in health facilities, when compared to women for whom this decision should be made by other people like their husbands and relatives(12, 22)

Women's Knowledge and Attitude towards Obstetric Risk

Several studies showed that women who knew danger signs of pregnancy, labour and birth complications, had favourable attitudes were more likely to use skilled birth attendant during delivery than those none knowledgeable and unfavourable attitude respectively(7, 15, 24, 25). A study done in India indicated that many women, though they received antenatal care services at health facility several items, they still preferred to give birth with the assistance of their family who and they could feel that where highly kept their privacy and feel that birth is a normal phenomenon that does not need an institutional setting(24). Progress in preventing and seeking care to reduce maternal deaths in rural Africa depends on women's and communities' knowledge and attitudes to maternal health. A study in Tanzania revealed that women who knew more the risk of pregnancy and labour danger sign are almost three times more likely to use skilled attendance at birth than those with poor

knowledge(29). Some study conducted in Ethiopia showed that knowledge of mothers about maternal and child health care was significantly lower for women who wanted to deliver at home compared to those who wanted to deliver at modern health institutions(22, 28).

2.2.2 Community and Cultural Barriers

2.2.2.1 Socio Cultural barriers

The health of the pregnant woman is managed traditionally based on several pre-determined and experienced beliefs within specific cultural settings(26). In many countries of south East Asia and Africa the main reasons behind the low coverage and utilization of skilled attendant care during delivery are cultural factors like; cultural norms, perceptions and practices of mothers including home remedies(7, 24, 26, 30).

A qualitative study conducted in Ghana showed that “a woman would have to prove herself as “real woman” by delivering alone”. Delivery without any care from anyone was thought to be a sign of true womanhood. Women who do not utilize the facility for delivery they use that as a way of proving their true women status and try to look down upon those who utilize the facility and consider them as very lazy and inferior. Some men also considered women who deliver at the facility as inferior, and also men thought as lucky if their wives deliver at home. The society was built up in a way that men are the decision makers. However when it comes to pregnancy and delivery the mother-in-laws have the largest mandate “all we know about pregnancy and delivery is that when our wives are pregnant, the first person to know is the mother in law, and if possible the husband is also made to know that the wife is pregnant. It is the mother in law that takes charge of her until she gives birth.”(31).

Qualitative Study findings from west Java ,Indonesia also revealed that TBAs have developed the feeling of trust in the community than the health workers because of not only they had been part of the community, speaking the local language, living in the community and sharing the same culture but also that the use and skills of Traditional birth attendants(TBAs) were appreciated by other family members such as the older sister, parents, or husbands to use their services; moreover, some participants and community members argued and stated that the midwives or trained

health professional services during delivery would be sought only if the condition could not be handled by the traditional birth attendant or for those experiencing obstetric complications(26)

2.2.3 Health Service Related Barriers

The availability of skilled birth attendant, supplies and equipment, accessibility of health institutions, the cost of health service and providers' attitude towards laboring mother and perception of community members towards quality of health service system were some factors that enabled mothers to utilize skilled attendant care(22). But in most developing countries the reverse was true in using maternal health services. The main reasons for women not to use available obstetric care during pregnancy, labor and delivery were poor access to health institutions, vehicles shortages, poor road condition, wealth and ability to pay for health care services (25, 26).

A study from Afghanistan revealed that walking distance from the household to the facility, availability of a female doctor or midwife at the facility, the type of health facility, presence of obstetrical equipment, and availability of routine antenatal care, wealth of the family were the strongest determinants of skilled birth attendant use (21). An explorative study on factors influencing mother's choice of place of delivery in rural Malawi showed that unsatisfactory availability of skilled delivery care in terms of distance, transport, cost and poor approach of health workers were found to be among the main factors that lead women to choose health facilities for delivery(15). One of the health workers explained that "Most of the women stayed very far from the hospital, in some places there are no transport services: no buses, they use bicycles, so it's a problem when the mother starts the labour." Moreover, the attitude of health workers was significantly influenced by the choice of place of delivery(15).

A qualitative study conducted in the Western region of Ghana reported that, during women's interviews, it was said that the health staff sometimes has a rough behaviour towards women e.g. slapping their thighs during labor, yelling at them when they come in a late stage of labour or do something wrong. The providers also give preferential treatment to clients who were expensively dressed up. Women reported that such misconduct by health workers kept them to shy away from coming to deliver at the clinic. One of the women reported "I will not go to the clinic because

of the nurses there. They are not good/kind to pregnant woman. If traditional birth attendants are giving the same treatment, why should I go to the clinic?"(31). Studies done in North showa, and Sekela District, West Gojjam showed that households who possess radio were more than three times likely to utilize delivery service in health facilities than those without radio and, previous exposure of delivery service, distance from the health facility, ever use of modern health services, maternal decision on use of health services had significant association with skilled attendant care during delivery. In Ethiopia different studies indicated the following reasons for home delivery including absence of health problems, short duration of labor, preferring the attention of relatives and more trust on traditional birth attendants or relatives than health professionals(20, 21, 32).

In summary, reviewed literature indicated that a range of factors including individual, health service related, community and cultural barriers affected use of skilled birth attendance.

2.3 Research Questions

After the literature reviewed the following research questions were proposed for this study:

- What is the level of skilled birth attendance in Ankasha Guagusa Woreda, Awi Zone, Amhara region?
- What are factors associated with skilled delivery attendance?
- What are personal, community and facility barriers associated with skilled birth attendance?

2.4 Conceptual Frame Work

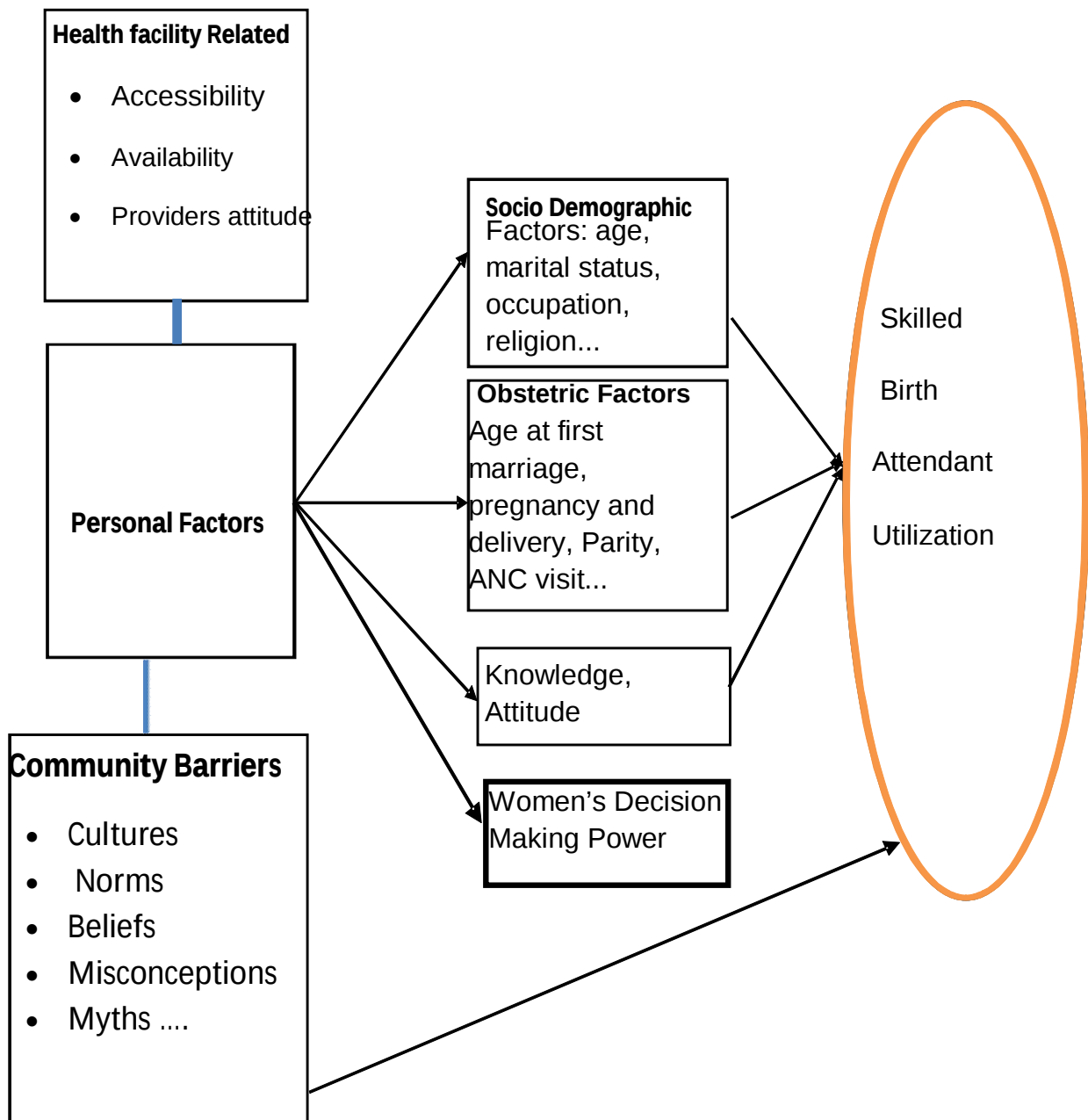


Figure 1: Conceptual Framework Showing the Association of Different Factors with Skilled Birth Attendance

This Conceptual Framework adapted from one developed for analyses of Reproductive Health Outcomes(33)

3. OBJECTIVE

3.1 General Objective

To assess skilled birth attendant utilization and associated factors among mothers who gave birth during the last one year in Ankasha Guagusa woreda, Awi Zone, Amhara regional State, North West of Ethiopia, 2014

3.2 Specific Objectives

- To determine the proportion of deliveries assisted by skilled birth attendant
- To identify factors associated with utilization of skilled birth attendant
- To explore barriers that affect skilled Birth Attendance at delivery in the study District

4. METHODS

4.1 Study Area

The study was conducted in Ankasha Guagusa Woreda which is one of the eight Woredas of Awi zone in Amhara Regional State. The Woreda was administratively divided in to five clusters, 29 Rural and 4 urban kebeles. The Woreda shares boundary with Banja Woreda in the North, Guagusa Shikudade Woreda in the East, Wonberma Woreda in the South and Guangua Woreda in the West. It has an area of 79881.75km² with an estimated population of 221,796 according to the 2007 Census. The average number of expected deliveries per annum in the Woreda is 6520 which is 2.94% of the total population. The woreda capital city Gemjabet is located at 450 km from Addis Ababa & 13 kms from the Zonal capital kosober, respectively. According to 2013 Ankasha Guagusa woreda health department report, there were seven health centers with five private and four public clinics where the population of these woredas routinely obtains maternal health care services. Totally 179 health professionals including health extension workers were currently working in the study district; 9 health officers, 5 B.Sc. nurse, 46 clinical nurses, 16 midwifery nurse, one pharmacy technologist, 9 pharmacy technicians, two laboratory technologist, 11 laboratory technicians and 80 health extension workers(17). In case of maternal health service utilization coverage; 28.4% mothers had fourth and above ANC visit, 21.7% of mother were delivered at health facility, and 74% of children had taken penta three immunization(17)

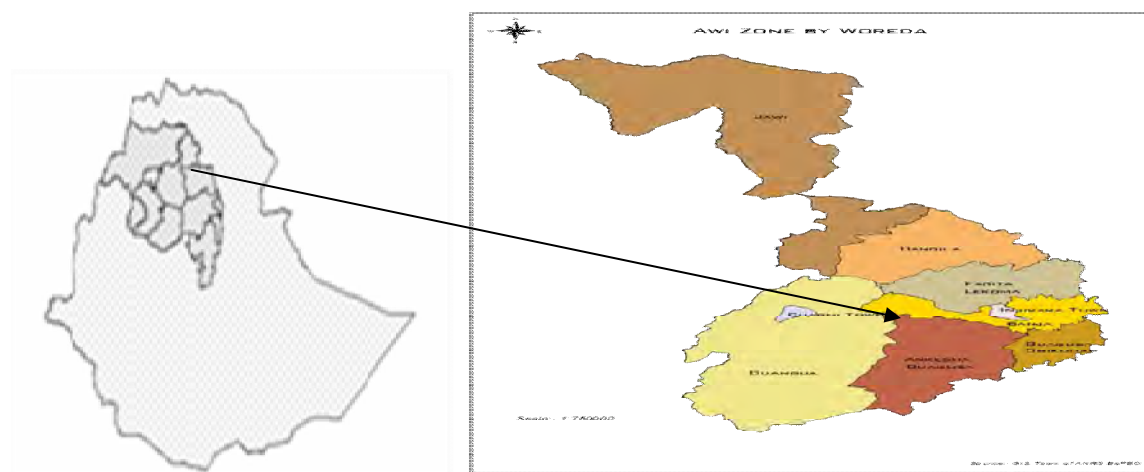


Figure 2: Map of Awi Zone and the Study Area

4.2 Study Design

The study employed community based cross sectional study design with a mix of quantitative and qualitative methods

4.3 Study Period

The study was conducted from February to March, 2014.

4.4 Source Population

Women of reproductive age (15-49 yrs.) residing in Ankasha Guagusa Woreda at the time of the study were considered as source population for the quantitative study. On the other hand community members who were more informed about the barriers that would negatively and positively affect utilization of skilled delivery attendance were discussants and key informants for the Focus Group Discussions (FGDs) and In depth Interviews (IDIs) that for the qualitative study.

4.5 Study Population

Women of reproductive age group who were permanently residing in Ankasha Guagusa Woreda who gave birth in the past twelve months prior to the survey were study population for the quantitative study. Whereas, health providers, leaders of Woreda Health Offices, Health Services Extension Workers, key informants from community leaders and religious leaders, residing in Ankasha Guagusa Woreda at the time of the study were the study population for the qualitative study.

4.6 Inclusion Criteria

Women of reproductive age group who gave birth in the past one year regardless of outcomes of pregnancy and permanently residing in the study district or stayed there for more than six months were considered as study participants.

4.7 Exclusion Criteria

Women, who were critically ill, unable to respond, at the time of the interview and those who could not be found in their respective homes in three subsequent visits were excluded from the study.

4.8 Sample Size Determination

The sample size is determined by using single population proportion formula

$$n = z_{\alpha/2}^2 * p * (1-p) / d^2.$$

Where n= Sample size

z= The standard z score value at 5% level of significance

P= Proportion of deliveries attended by skilled birth personnel of Amhara

Region is 10.1%(8).

d= degree of precision (4%)

With value of p is 0.101 and the desired error degree of precision chosen at 0.04 with $z_{\alpha/2}=1.96$, the required sample size, $n = \frac{(1.96)^2 (0.10 * 0.90)}{(0.04)^2}$

n=216. The study did employ multi stage technique. Then multiplying by a design effect 1.5) = we got 324. Adding 13% non-response rate the overall sample size was 373.

4.9 Sampling Procedure and Technique

4.9.1 Quantitative Study Procedure

The study used a multi-stage sampling scheme. First Ankasha Guagusa woreda was recruited purposely from eight woredas from Awi zone. Initially, three clusters from available five clusters were selected randomly; of the three clusters a total of six kebeles, 2 from 4 urban and 4 from 29 rural kebeles were selected and included by using simple random sampling technique. Each cluster represented by two: two kebles; Agew gemjabet cluster represented by one urban (Gemjabet 01) and one rural (Bekafeta) Keble with 4600 and 6245 number of populations respectively. Azena cluster was represented by Azena 01(urban) Keble with 3970 total population and Dugele Keble 7114 the total population; Degra cluster represented by Dengusha and Chara kebele with 6242 and 7315 total HHs respectively. The number of women who delivered in the past one year was obtained from Health Services Extension Workers (HSEWs) in selected kebeles. The sample size was then distributed proportional to the size of women who delivered in the past one year. Mothers were randomly selected from the rosters of HSEWs to recruit as study participants for this study (Fig. 2). Representative size of sample was obtained by using proportional to population size of the 3 clusters of the study woreda by population proportion to size

(PPS) formula. Finally by communicating with the HSEWs each kebeles and starting point of each locality was randomly selected and going in each specific house hold and mothers who delivered in the last 12 months were interviewed until the total sample size were obtained.

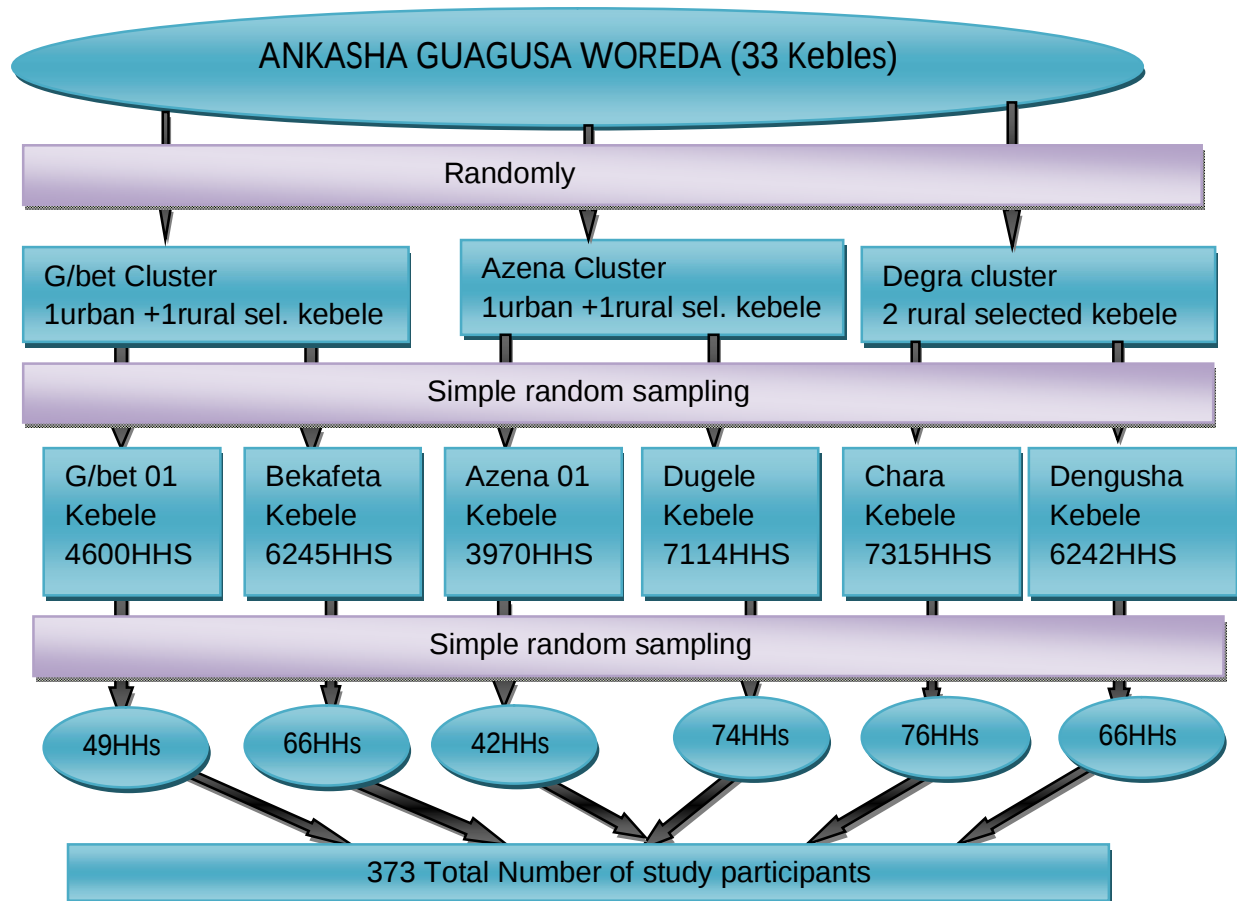


Figure 3: Schematic Presentation of Sampling Procedures

Note –HHS – households -G/bet-Gemjabet -sel. - selected Kebeles

4.9.2 Qualitative Study Procedure

Snow ball sampling procedure were used to select key informant interviewees were whereas maximum variation sampling procedure was employed to form different focus group discussion groups in a variety of clusters in the population. Clusters for the qualitative study were urban and rural residence type, religious and community leaders and educational level. The sample size for in depth interview and focus group discussion were determined by saturation of ideas.

4.10 Data Collection Tools

4.10.1 Quantitative Study Tools

Structured questionnaire was adapted from EDHS and related surveys. The questions included, current situation of safe delivery service, issues affecting institutional delivery including how and who made decisions regarding place of delivery and other.

4.10.2 Qualitative Study Tools

In Depth Interviews (IDI) - were individually conducted to investigate personal perspectives and sensitive issues, towards cultural norms, attitudinal factors like health care providers competence towards labouring mother, community misconceptions and other barriers which were obstacle to use skilled birth attendances.

Focus Group Discussions (FGD): -The aim of focus group discussion was used to obtain and understands more contextual factors, barriers and other related factors in the community and health facility.

Audio Recorder: - were used to scribble notes.

4.11 Data Collection Procedure

4.11.1.1 Quantitative Study Procedure

4.11.1.2 Selection and Training of Data Collectors

Twelve clinical nurses who were fluent speakers of the local languages and two health officer supervisors from the respective woredas were recruited and trained for two days. The training course had been given by the Principal Investigator (PI) prior to data collection. The sessions of the training included purpose and objectives of the survey, meanings of each question and techniques of interview. In addition, the role and responsibilities of data collectors and supervisors were also included. Besides, principles of data collection and keeping privacy during interview and confidentiality of information were given emphasis.

4.11.1.3 Pre Testing of the Questionnaire

The questionnaire was pre- tested on 10 eligible women which were not included in the study. Findings during the pilot study had been discussed among data collectors and supervisors, therefore; the tool had been modified before actual data collection. The final interview was conducted at participants' home at convenient time and place arranged by the data collectors and the women using the modified questionnaire.

4.11.2 Qualitative Study Procedure

Interview guides were prepared by reading different literatures for both in-depth interview and focus group discussions. The interview was conducted among Health care providers, health extension workers, key informants from community and religious leaders residing in Ankasha Guagusa woreda. Homogenous discussants were recruited in each group. Discussions were moderated by PI. Each discussant was made speak out from their minds. Every discussant was encouraged to talk without repeating what others had already said. Dominant speakers had not been allowed to control the whole discussion. Silent speakers were also being encouraged to air their views. Overall, a total of 32 participants under three focus group discussions comprised of male and female discussants from community and religious leaders were participated. Furthermore, six in-depth interviews that comprised two health officers, one midwife, one clinical nurse, and two health extension workers were involved during the study.

4.12 Variable

4.12.1 Dependent Variable:-

- Use of Skilled Birth attendance

4.12.2 Independent Variables

- 1) **Socio-demographic:-** age, women's education, husband education, women's autonomy, women's and their husband's occupation, ethnicity, religion and income
- 2) **Past Obstetrical profile:** - age of pregnancy and birth, parity, ANC visit.
- 3) **Health service factors** -geographical accessibility of care like distance to facility, availability of health care providers, provider attitude towards laboring mother.
- 4) **Individual factor:** - women's attitude and knowledge towards pregnancy and child birth, satisfaction by the care given at health institution, decision making power.
- 5) **Cultural factors:-**Traditional beliefs, misconceptions, myths, community perception towards facility delivery.

4.13 Data Quality Control

Data quality was ensured during collection, coding, entry and analysis. During data collection, adequate training and follow up was provided to data collectors and supervisors and questionnaires were pre-tested. Supervision of data collectors included observation of how they administered the questionnaires and random revisit on required number of households by supervisors and the principal investigator. Codes were given to the questionnaires and households during the data collection. So that any identified errors were traced back using the codes. Completed questionnaires were being checked for completeness by data collectors, supervisors and the principal investigator on a daily basis. Consequently, any of problems encountered were discussed among the survey team and solved immediately. Finally, data were thoroughly cleared and organized before analyses.

4.14 Data Analysis

4.14.1 Qualitative Data Analysis

The qualitative data was moderated by the principal investigator of the study. A note taker was involved to scribble notes on the discussion. Moreover, the discussion was tape recorded after consent was obtained from discussants and interviewees. Transcription of the audio material was done word by word. The transcripts were then translated to English language by the principal investigator. Open Code Software was used to code and categorize qualitative data. Data were then analysed thematically. Verbatim (views of study participants) were quoted in instances where it was necessary in the qualitative report.

4.14.2 Quantitative Data Analysis

Following the data collection process, each questionnaire was checked manually for completeness. The corresponding code number had been written carefully at each margin. The principal investigator put the data into the computer using EPI INFO version 3.5.4 software. Data was exported to SPSS version 21.0 for data cleaning and analysis. Descriptive summary measures had been used to describe the study population and measure the level of skilled birth attendance. Moreover, the overall association between different background characteristics of the respondents and skilled birth attendance had been analyzed using chi squared test. Multivariate association between factors and skilled birth attendance had been done using crude and adjusted odds ratio along with their 95% Confidence Interval (CI) in Binary Logistic Regression. After gathering the qualitative data, first properly transcriptions of the collected data from audio material and note taker then the transcripts were translated to English language by PI. Finally open code software was used to code and categorize qualitative data. Data were then analyzed thematically as much as possible Verbatim (views of study participants) were quoted in instances where it was necessary in the qualitative report.

4.15 Operational Definitions

Access to health facility: The pregnant women being no more than an hour from health facility by local means of transportation, or availability of health facility within one hour's walk or travel

Attitude of health staff: Affective behavior of health staff towards clients and relatives.

Favorable attitude: women who respond positively towards maternal health care services and related questions more than the median score.

High knowledge: mothers who knew more than three accept pregnancies and labour danger signs.

Health facility: Health institutions which includes hospitals, health centers and health posts.

Low knowledge: mothers who mentioned at most three accept three danger signs of pregnancy and labour.

Parity:-total number of delivery that occur after 28 wks of gestational age.

Permanent residence: Women who have been residing in the study area, for at least six month prior to the data collection.

Skilled Birth Attendant (SBA): are professionally trained health workers usually a doctor, midwife, or nurse with the essential skills to manage normal labour and delivery, recognize complication early and perform any essential interventions.

Unfavorable attitude: women who respond less than the median score towards maternal health care services and related attitude questions.

Women's autonomy: Decision-making power of women on one's own choice of delivery place

4.16 Result Dissemination Plan

The thesis will have been defended at the School of Public Health, College of Health Science in Addis Ababa University and a short report shall be communicated to the Zonal Health department. A presentation at professional, local, national and international meetings and publication in peer reviewed national and international journals would be attempted.

4.17 Ethical Clearance

The proposal was reviewed by Research Ethics Committee of the School of Public Health, Addis Ababa University. The survey was commenced after written consent was obtained from the Woreda Administration Council. Informed verbal consent was secured from each study participants after they were informed on the purposes of the study. Assurance of privacy and confidentiality were done.

5. RESULTS

5.1 Quantitative

373 women who had given birth in the past one year before the survey were interviewed. First factors associated with skilled birth attendance yet presented thematically as: socio demographic and obstetric characteristics, knowledge and attitude of the respondent's, accessibility and availability and utilization of health facilities of respondents. Descriptive and analytic findings from the bivariate and multivariate regression model were shown. Finally, qualitative findings were presented thematically.

5.1.1 Socio Demographic Characteristics of the Respondents in Ankasha Guagusa District, Awi zone, Amhara region

According to the socio-demographic profiles of the study participants, 282 (75.6%), of study participants were residing in rural area. Two hundred ninety five (79.1%) were aged 20-34yrs with mean + SD of their age group were 30.4 ± 5.6 yrs.

Almost all, 367(98.4%), respondents were Orthodox Christian followers and only 6(1.6%) were Muslim religion followers; more than half, 290(77.7%), of respondents were Agew and the remaining, 83(22.3%), of respondents were Amhara. Regards to the respondents marital status, 347(93%), were currently married with mean + SD of marriage age were $16.4 + 3.8$ yrs and the other 26(7.0%), of mothers were non unions. From mothers who were currently in union, 19(5.8%), of respondents revealed their husbands were polygamous. In the case of respondents education, more than half, 233(62.5%), of respondents never had formal schooling, 86(23.1%), had completed primary and the 54(14.5%) had attained secondary and above educational level. Of the total respondents, majority, 258(69.2%), of respondents were farmers, but, 73(19.6%) and 42(11.3%) were private and governmental employees respectively. As far as women's husbands education and occupation status was concerned, more than half, 192(55.3%), of their husbands were unable to read and write, 88(25.4%) were primary completed, and 67(19.3%) were secondary plus level of education. Moreover, 264(76.1%), of their husbands were farmers, 38(11.0%), of them were private employers and the rest 45(12.9%) were governmental employees. Majority, 243(65.1%), of women had more than four regular members in their house hold.

Concerning women's autonomy, 78(47.7%), of women decides equally for their spending money for maternal health care and other household needs. On the other hand, as they informed that 89(23.9%) of the respondents husbands were decision makers for all basic needs including health service care.

Table 1: Socio Demographic Characteristics of the Respondents in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

Variable	Frequency	Percent
Residence		
Rural	282	75.6
Urban	91	24.4
Age group		
<20yrs	10	2.7
20-34yrs	295	79.1
35-49yrs	68	18.2
Mean $\pm$ SD 30.4 $\pm$ 5.6		
Religion		
Orthodox	367	98.4
Muslim	6	1.6
Ethnicity		
Agew	290	77.7
Amhara	83	22.3
Women's current marital status		
Currently Married	347	93.0
Not in Union*	26	7.0
Husband's polygamous status		
No	328	94.5
Yes	19	5.5
Women's educational status		
No education	233	62.5
Primary	86	23.0
Secondary and above	54	14.5
Women's current occupation		
Farmer	258	69.1
Private employee*	73	19.6
Governmental employee	42	11.3
Husbands' current educational status		
No education	192	55.3
Primary	88	25.4
Secondary and above	67	19.3
Husbands' current occupation		
Farmer	264	76.1
Private employee*	38	11.0
Governmental employee	45	12.9
House hold size(HHS)		
<4 HHS	130	34.8
>4HHS	243	65.2
Monthly income		
< 1500Birr	255	68.4
$\geq$ 15000Birr	118	31.6
Source of income		
Myself	54	14.5
Family/relatives	52	13.9
Both	178	47.7
Husbands	89	23.9

Non union*:- single, separated, widowed, divorced Private employee*:- student, merchant, handcraft, daily labourer.

5.1.2 Obstetric Characteristics of the Respondents in Ankasha Guagusa District, Awi Zone, Amhara region

Major Obstetric factors that have been related with utilization of skilled birth attendance were assessed and presented as follows.

According to this study, more than half of women 221(59.2%) established their first marriage before they celebrated their 16th birthday with the mean $\pm$ SD of first marriage 16.4 $\pm$ 3.8yrs; and 267(71.2%), of study participants enforced in to their first pregnancy at the age of 20 years and above with the mean $\pm$ SD of first pregnancy at 19.7 $\pm$ 2.99 yrs. Regarding women's antenatal health service utilization, majority, 258 (69.2%), of mothers who recently were pregnant had received ANC visit at least once. Among them, 151 (53.0%) had two to three ANC visits, only 45(15.8%) had four and above ANC visits. However, more than half, 150(52.6%), of the pregnant mothers started ANC follow up at gestational age less than four months (on the first trimester), where as the remaining, 135(47.4%) had started more than four and above of the gestational age of their pregnancy (Table 2).

In case of respondents delivery assistance, 231 (61.9%), of them reported that their most deliveries were assisted by their relatives and families, whereas, 70 (18.8%), of study participants had delivered by using skilled professionals and 60 (16.1%) were assisted by village based health extension workers; the remaining, 12 (3.2%), of mothers delivered their babies by themselves without being attended by anyone. of which institutionally delivered mothers, 43(61.5%), of them gave birth with spontaneous vaginal delivery, 21(30.0%) with instrument and the rest 6(8.6%) of women with caesarean section. On the other hand, 71(19.0%), of women who gave birth in the last one year had history of problem during labour time among which 64(85.7%) went to health facilities while 8(11.3%) consulted traditional healers of respondents (Table 2).

Table 2: Obstetric Characteristics of the Respondents in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

Variable	Frequency	Percent
Age at 1st marriage		
<16yrs	221	59.2
>16yrs	152	40.6
Mean $\pm$ SD	16.43 $\pm$ 3.82	
Age at 1st pregnancy		
<20 yrs	106	28.8
>20yrs	267	71.2
Mean $\pm$ SD	19.7 $\pm$ 2.99	
Parity		
<4 children	228	61.1
>4 children	145	38.9
Received ANC in the last pregnancy		
Yes	258	69.2
No	115	30.8
Frequency of ANC visit		
1 st visit	89	31.2
2 nd & 3 rd visit	151	53.0
4 th and above	45	15.8
At what gestational age ANC visit were started?		
	150	52.6
< 4 months	135	47.4
>4 months		
Delivery assistance		
Skilled birth attendant	70	18.8
Health extension workers	60	16.1
Family/relatives	243	61.9
Myself	12	3.2
Mode of delivery		
Spontaneous vaginal delivery	43	61.4
Instrumental delivery	21	30.0
Caesarean section	6	8.6
Any problem during current delivery		
No	302	91.0
Yes	71	19.0
Measures taken for the problem		
Went to health facilities	64	85.7
Took traditional medicine	8	11.3
Others* none home		

Regarding respondents choice of place of delivery majority, 295(79.1%), of the respondents gave birth at home while only, 78(20.9%), of respondents gave birth at health institution. Among the respondents who gave birth at health institution, only 70(18.8%), of respondents were attended by skilled birth attendants during delivery. (See the rest on the Figure 3).

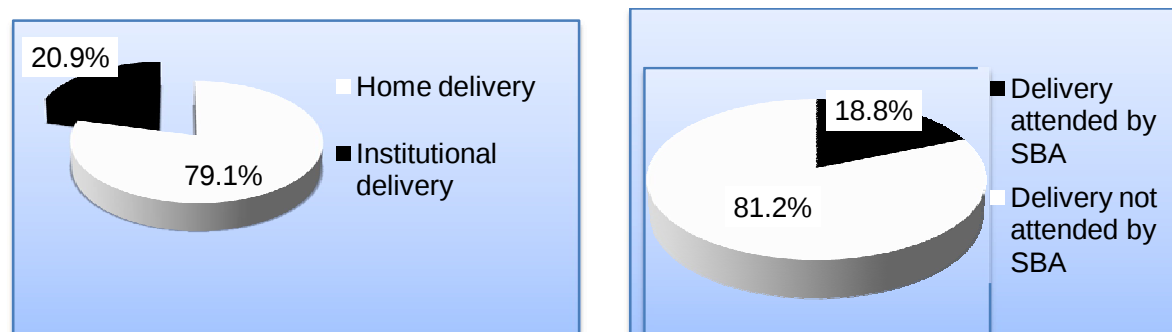
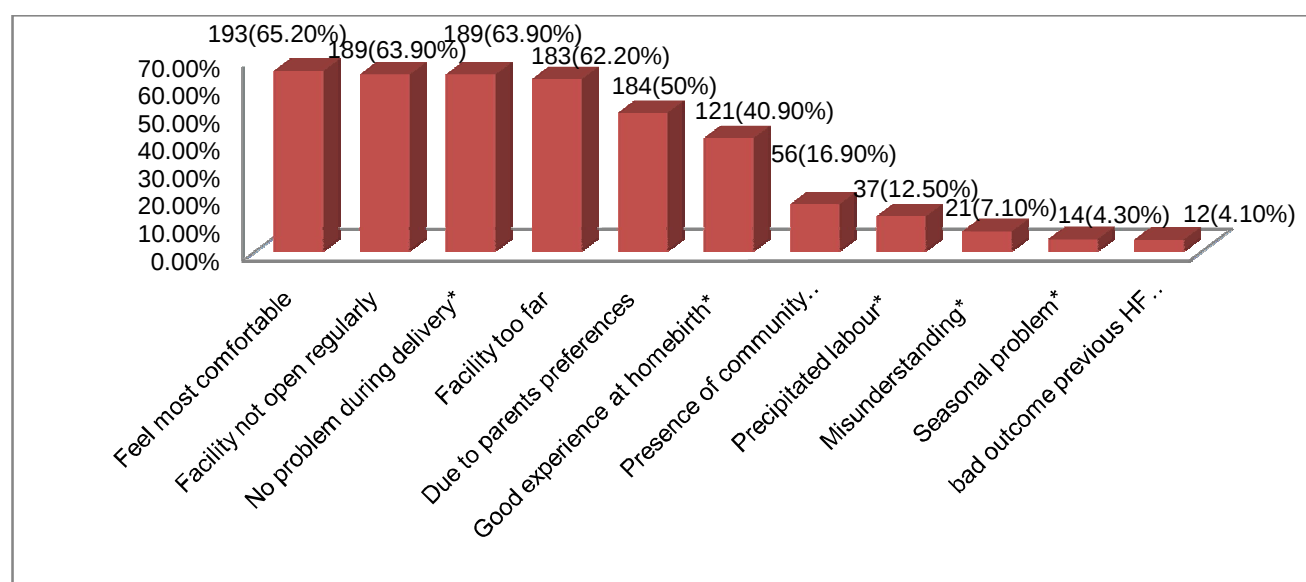


Figure 3: Institutional Delivery and Skilled Birth Attendance Levels in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

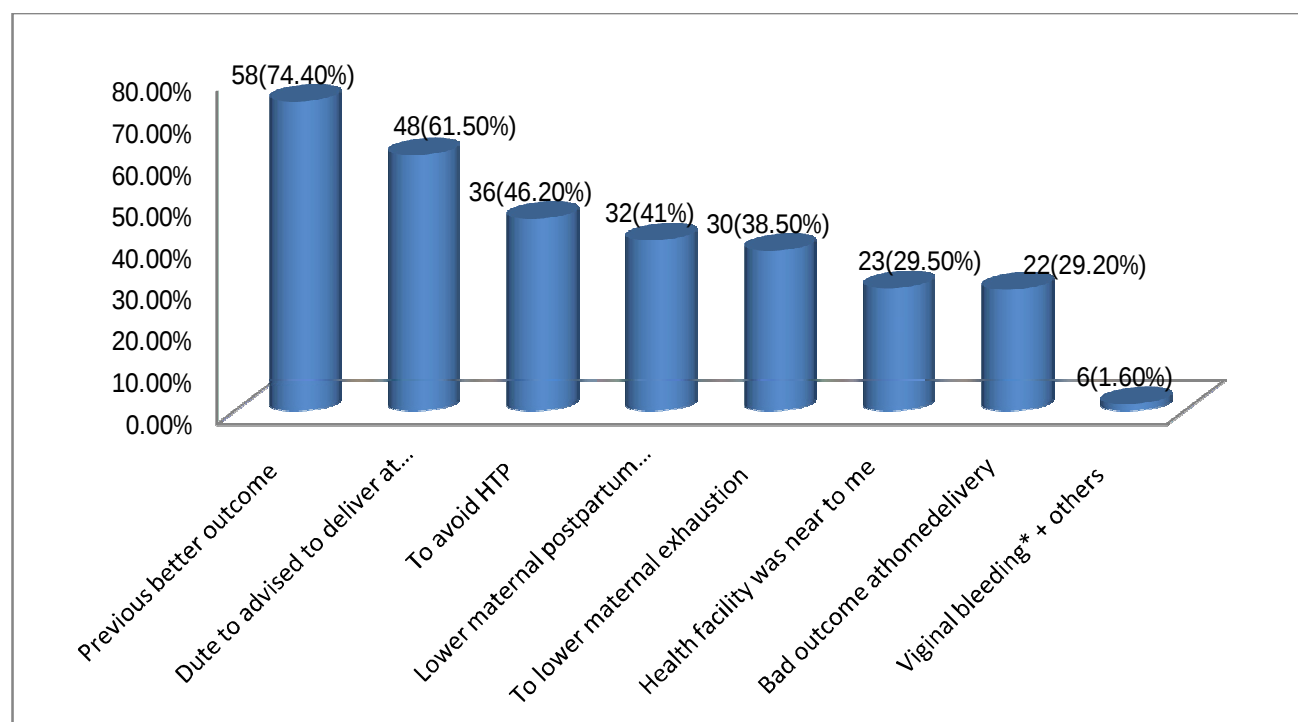
The main reasons why majority of respondents chose to give birth at home were summarized on table 4, below. Affirmatively, multiple answers were expected. Most of the respondents, 193 (65.2%), of claimed that they had given birth at home accompanied by families and friends is good while another majority, 189(63.9%) reiterated that they did not have any problem during labor and health facility not open regularly. Facility distance from home as hindrance for institutional delivery was mentioned by, 184 (62.2%), of the study participants.



***Others**

Figure 4: Reasons for Home Delivery of Respondents in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014.

When women were asked why they delivered in health facilities, 58(74.4%), of them said they wanted to have better health outcome for them and their children, while 48(61.5%) was advised by health providers to give birth at health facilities and 36(46.2%) of them wanted to avoid harmful traditional practices. (See the remaining on the table 4 below).



*others

Figure 5: Reasons Mentioned for Institutional Delivery in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

5.1.3 Knowledge and Attitude of Respondents towards Skilled Birth Attendance Utilization in Ankasha Guagusa Woreda District, Awi Zone, Amhara region

5.1.3.1. Knowledge of Respondents about Maternal Health Problem, Pregnancy and Labor Danger Signs

According to this study, more than, 187(51.0%), of respondents didn't know pregnancy danger signs. While, 186(49. %), of study participant mentioned at least one accepted danger signs of pregnancy, among them, 153, (81.8%), of mother said vaginal bleeding, 108(57.8%), of respondents mentioned leg or body swelling, 128(78.4%), of respondents identify reduced/absence of fetal movement and the rest respondents mentioned on the table 3 below accordingly. Of these only fifty eight

(31%) of the respondents mentioned at least three danger sign of pregnancy and categorized as high knowledge.

One hundred fifty five (41.6%) mothers knew presence of pre birth preparedness and complication readiness. Of those who had knew presence of pre birth preparedness and complication readiness, 121(78.1%) knew preparation of items for labour, 107(69.0%), of them told saving many for further need, 78(50.3), of respondent choose and arrange where their place of delivery before labour will occur. In this regard mothers who scored 50 (32.3%) in related to knowledge of pre birth preparation and readiness for complication were categorized as high knowledge (See on Table 3).

Concerning respondents knowledge about labor and delivery danger signs, 153(49.0%) knew at least one major danger signs of parturition. of which, vaginal bleeding 122(79.2%), retained placenta, 100(64.9), early rupture of membrane, 83(53.9), followed by Prolonged labor greater than 12hrs, 42(27.3%) consecutively were mentioned by respondents. Relatively 51, only (33.1%) respondents correctively chosen at least three labour danger sign labeled as high knowledge.

According to this result, over all respondents' knowledge category in related maternal health problem, pregnancy danger signs, birth preparedness and complication readiness and labor danger signs sign was low i.e. majority of respondents respond below the median score, 196(52.5%).

Table 3: Knowledge of Respondents about Maternal Health related Problem in Ankasha Guagusa Woreda, Awi, Zone North West, Ethiopia, 2014

Variable	Frequency	
	No	Yes
Knowledge about danger signs during pregnancy	187(51.0%)	186(49.0%)
Mentioned pregnancy danger signs		
Vaginal bleeding	34(18.2%)	153(81.8)
Swelling of leg/face	79(42.2%)	108(57.8%)
Severe head ache	116(62%)	71(38.0%)
Blurring of vision	132(70.6%)	55 (29.4%)
Reduced/absence of fetal movement	59(31.6%)	128 (78.4%)
Abnormal body movement	180(93.3%)	7(3.7%)
Severe abdominal cramp	155(82.4%)	33(17.6%)
Excessive weight gain	181(96.8%)	6 (3.2%)
Fever	167(89.3%)	20(10.7%)
Total knowledge category		
Low	129 (69%)	
High	58 (31%)	
Knowledge about Birth Preparedness & Complication Readiness (BPCAR)	218(58.4%)	155(41.6%)
Mentioned birth BPCAR		
Identify place of delivery	77(49.7%)	78(50.3%)
Preparing essential items for clean & postpartum period	34(21.9%)	121(78.1%)
Identify place of delivery	131(84.5%)	24(15.5%)
Identifying danger signs	101(65.2%)	54(34.8%)
Identifying better and nearest health services facility	126(81.3%)	29(18.7%)
Designating decision maker on her behalf	143(92.3%)	12(7.7%)
Arranging a way for communication & transportation	112(72.3%)	43(27.7%)
Saving money for emergency cases	48(31.0%)	107(69.0%)
Preparing of blood donor	152(98.1%)	3(1.9%)
Total knowledge category		
Low	105(67.7%)	
High	50(32.3%)	
Knowledge about labor danger signs	220(51.0%)	153(49.0%)
Mentioned labour danger signs		
Prolonged labor greater than 12hrs	112(72.7%)	42(27.3%)
Early rupture of membrane	54(35.1%)	100 (64.9%)
Mal-presentation	113(73.4%)	41 (26.6%)
Convulsion	143(92.9%)	11 (7.1%)
vaginal bleeding	32(20.8%)	122(79.2%)
Placenta retention >1hr	71(46.1%)	83(53.9%)
Increased Blood Pressure	125(81.2%)	29 (18.8%)
Cessation of labor pain	129(83.8%)	25 (16.2%)
Total knowledge score of labour danger signs		
Low	97(71.9%)	
High	38(28.1%)	
Overall respondents knowledge category		
Low	196(52.5%)	
High	177(47.5%)	

5.1.3.2. Attitude of Respondents on Skill Birth Attendance Utilization in Ankasha Guagusa District, Awi Zone, Amhara Region

Regarding this study, questions of attitude towards maternal health and utilization of skilled birth attendance were indicated on table 4, below. Accordingly, more than half, 196(52.5%), of them expressed their disagreement on facts related to the preventability of labour and delivery complication, 97(52.8%), of mothers believe every mother did not face problem with related to pregnancy. But, 215(57.6%) of study participant perceive they are at risk as being a pregnant and labouring mothers. Besides, 281(75.3%), of respondents identify the fate of pregnancy and labor may have positive or negative impact in both their life and new born baby. And also, majority, 325(87.1%), of mothers agree with antenatal and delivery follow up during pregnancy and delivery by skilled birth attendance results better outcome in both health of newborn and mother. On the other hand concerning health providers competency 212(56.8%) of mothers said skill health professionals assigned near to their health facility were qualified enough to refer further and recognize complications. However; 249(66.8%), of respondents who identify health facility near them did not have adequate lifesaving infrastructure for delivery service. on the contrary more than half, 22(59.5%) mothers perceive one laboring mothers can give birth in her home normally, if problem did not occur during labour.

To summarize, respondents' attitude towards pregnancy problems and management of labour and delivery was below the median score (unfavourable).

Table 4: Attitude of Respondents about Maternal Health related Problem in Ankasha Guagusa Woreda, Awi, Zone North West, Ethiopia, 2014

Variable	Disagree (%)	Agree (%)
Most labor and pregnancy problems are preventable	196(52.5%)	177(47.5%)
Every pregnant mother face problem during labor& pregnancy	197(52.8%)	176(47.2%)
I am at risk of pregnancy and labor problem	158(42.4%)	215(57.6%)
Outcome of pregnancy and labor may affect new born and mother's life	92(24.7%)	281(75.3%)
ANC and delivery follow up by SBA result in health newborn and mother	48(12.9%)	325(87.1%)
Most of HWs have the capacity to refer before problem arise	161(43.2%)	212(56.8%)
Most HFs have enough equipment and supply for delivery service	249(66.8%)	124(33.2%)
Laboring mother without any problem might give delivery at home	151(40.5%)	222(59.5%)
Attitude category towards pregnancy problems and management of labour and delivery		
Low	207(55.5%)	
High	166 (44.5%)	

5.1.4. Accessibility, Availability and Utilization of Health Facilities of Respondents in Ankasha Guagusa District, Awi Zone, Amhara region

Regarding health service availability, accessibility, and utilization of respondents, overwhelming, 366(98.1%), of study participants had proximate health facility. Of which, only 91(24.9%), of study participants had proximate health centre with less than one hour walking distance. However, 275(75.1%), of mothers had reside near to health post, of which majority, 210(56.3%) and 36(9.7%), of the study participants were situated 1-2 hours and greater than 2 hours walking distance respectively. Concerning pervious history of facility delivery, as table 5, depicted, only 97(26.0%) of participants had given birth at health facility. more than half, 57(58.5%) and 24(68.6%), of them were served with free in charge and ability to pay to delivery services respectively. Concerning health care provider's attitude towards labouring mothers, most of participant revealed, not all, but, only 286(76.7%), of health care providers had positive attitude towards labouring mothers.

Table 5: Accessibility, Availability, and Utilization of Health Facility by Respondents in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

Variable	Frequency	Percent
Availability of Health facility		
No	7	1.9
Yes	366	98.1
Type of health facility		
Health post	275	75.1
Health centre	91	24.9
Distance of health facility		
<1hrs walking distance	127	34.0
1-2hrs walking distance	210	56.3
>2hrs walking distance	36	9.7
Ever gave birth at health facility		
No	276	74.0
Yes	97	26.0
Payment modalities		
Free of charge	57	58.8
On payment	35	36.1
I do not remember	5	5.1
Ability to pay		
Yes	24	68.6
No	11	31.4
Health care provider attitude towards labouring mothers		
Favourable	286	76.7
Non favourable	87	23.3

5.1.5. Community Based barriers towards Utilization of Skilled Birth Attendance in Ankasha Guagusa District, Awi Zone, Amhara region

Community related questions about skilled delivery attendance during delivery were interviewed. As table 6, below shows, 184(53.0%), of respondents mentioned; their husbands had good attitude towards attending delivery service at health facility, on the contrary, 163(47.0%), of their husbands' didn't have interest to be assisted by skilled birth attendants; because of, 81(23.3%) respondents revealed, health workers bad attitude towards labouring women, 14(4.0%), of their husbands choose due to inability to perform cultural ceremonies at health facility and 12(3.5%) of them considering giving birth at home is most comfortable and safe than giving birth at

modern health facility. Regarding respondents family preference of delivery assistance during labour, most, 232(62.2%), of respondents' family preferred their labouring mother to be attended by their own family, 127(34.0%) preferred to be assisted by skilled birth attendance and the remaining, 14(3.8%), of women want to be delivered by community health extension workers. Final community related profile of respondents end up with women's history of taking traditional medicine during delivery time. Few, 40(10.7%), of respondents had took traditional medicine during recent delivery for 35(9.4%) of respondents used for facilitating labour, 29(7.8%), relief pain and 6(1.6%) prevent labour complication.

Table 6: Community related Factors with Skilled Birth Attendant in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014.

Variable	Frequency	Percent
Husband attitude towards delivery service given HF		
Favourable	184	53.0
Non favourable	163	47.0
Reasons for husbands negative attitude towards health facility delivery		
They take many time	4	1.2
Unable to perform cultural ceremonies	14	4.0
Due to health providers unpleasant approach	81	23.3
Home is better for comfort and safety	12	3.5
Family preference of delivery assistance during labour		
Skilled delivery attendant	127	34.0
Health extensions workers	14	3.8
Family	232	62.2
Any traditional medicine used?		
Yes	333	89.3
No	40	10.7
Reasons used traditional medicine during labor		
To facilitate labor	35	9.4
To prevent complication	6	1.6
To relive labor pain	29	7.8

5.1.6. Factors Associated with Skilled Birth Attendance in Ankasha Guagusa District, Awi Zone, Amhara region

In this section, bivariate and multivariate analysis was performed between skilled birth utilization (dependant variable) and each of the determinant factors associated with skilled birth attendance utilization (independent variable). Their odds ratios (OR) at 95% confidence intervals (CI) and p-values were obtained. Socio-demographic Characteristics associated with Skilled Birth Attendance

The following section reveals the association of various covariates with skilled birth attendance. The bivariate and multivariate association with skilled birth attendance is shown for each of the variables considered in this study one after the other. Residence has been found to be strongly and significantly associated with skilled birth attendance at both bivariate and multivariate level. Skilled birth attendance was COR=7.80: 95% CI (4.41, 13.70) times more likely to be utilized among urbanites compared with rural residents of Ankasha Guagusa District. When other confounding socio-demographic variables are controlled, the odds of skilled birth attendance utilization were AOR=5.51: 95% CI (2.23, 13.54) times higher among urban residents compared with their rural counterparts.

With regards to women's educational level the significance of association vanishes at multivariate level for primary level of education. Skilled birth attendance was COR=2.42: 95% CI (1.23, 4.75) and COR=10.59: 95% CI (5.33, 21.05) times more utilized likely among mother who completed primary and secondary plus level of education respectively compared with those who had never been into formal schooling. On the other hand when all the other socio-demographic variables are controlled, the odds of skilled birth attendance were AOR=6.2: 95% CI (1.31, 30.05) times more likely to be attained to those respondents whose education were secondary and above than those with no education.

As far as occupation of mothers and husbands were concerned, both mothers' and husbands' occupations in bivariate analysis were highly associated with skilled birth attendant utilization. Skilled birth attendant utilization among private and governmental employees were COR= 2.40: 95% CI (1.25, 4.60) and COR=7.32: 95% CI (3.40, 14.92) times respectively more likely utilized than those mothers

whose occupation were farming. In case of their husband's occupation, wives of private employees were COR= 9.00: 95%CI (4.28, 18.96) times more attended their delivery by skilled birth professionals than those wives of farmers and governmental employees. Whereas, both women's and husbands' occupation did not show the association with utilization of skilled birth attendance if confounded with other socio-demographic variables. About their husbands polygamous, women with husband with multiple spouses were 64% less likely attended their delivery service by skilled birth professional than those counterparts. However, where confounding factor was controlled polygamist vanishes from its association with dependant variable.

Regarding household members of the respondents, mothers who had less than four household members were COR= 2.53: 95CI (1.49, 4.30) times more likely assisted by skilled professionals during delivery than their counterparts. In other words, as maternal house hold size increases the likely hood of to be assisted by skilled professionals during delivery will decreases. The significance of the number of household members with skilled birth assistances vanished when other socio demographic covariate were cofounded.

According to this result, the odds of skilled birth attendance utilization among mothers who obtained money from their own and decide themselves were COR= 3.17: (1.41, 7.14) higher than those mothers who obtained from their won husbands and other family and relatives. But it was insignificant when it was confounded with other variables (See Table 7).

Table 7: Socio Demographic Characteristics Associated with Skilled Birth Attendance in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

Variable	Skilled birth assistance		COR (95%CI)	AOR (95%CI)
	No %	Yes%		
Residence				
Rural	254(90.1)	28 (9.9)	1.00	1. 00
Urban	49(53.8)	42 (46.2)	7.8(4.41, 13.70)*	5.51(2.23, 13.57)**
Women education				
No education	210(90.1)	23(9.9)	1.00	1.00
Primary	68(79.1)	18(20.9)	2.42(1.23, 4.75)*	2.06(0.68, 6.25)
Secondary and above	25(46.3)	29(53.7)	10.59(5.33, 21.05)*	6.27(1.31, 30.05)**
Husbands education				
No education	171(89.6)	20(10.4)	1.00	1.00
Primary	78(88.6)	10(11.4)	1.10(0.49, 2.45)	0.59(0.02,1.77)
Secondary & above	33(49.3)	34(50.7)	8.86(4.55,17.25)*	1.61(0.35, 7.45)
Women occupation				
Farmer	227(88.0)	31(12.0)	1.00	1.00
Private employee	30(66.7)	15(33.2)	2.40(1.25, 4.60)*	0.26(0.28,2.3)
Governmental worker	18(47.4)	20(52.6)	7.32(3.40, 14.92)*	0.23(0.02, 2.80)
Husband occupation				
Farmer	235(89.0)	29(11.0)	1.00	1.00
Private employee	30(66.7)	15(33.2)	9.00(4.28, 18.96)*	1.39(0.10, 18.37)
Governmental worker	18(47.4)	20(52.6)	4.05(1.95, 8.41)*	1.21(0.11, 13.04)
Polygamous				
No	12(63.2)	7(36.8)	0.36(0.14, 0.96)*	0.37(0.12, 1.22)
Yes	271(82.6)	57(17.4)	1.00	1.00
House hold size				
<4HHS	93(71.5)	37(28.5)	2.53(1.49, 4.30)*	1.22(0.59, 2.53)
>4HHs	210(86.4)	33(13.6)	1.00	1.00
Source of money				
Myself	35(64.8)	19(35.2)	3.17(1.41, 7.14)*	1.64(0.56, 4.82)*
Family	45(86.5)	7(13.5)	0.91(0.34, 2.45)	1.43(0.44, 4.59)*
Both	147(82.6)	31(17.4)	1.23(0.61, 2.49)	0.80(0.33, 1.93)*
Husbands	76(85.4)	13(14.6)	1.00	1.00

*Bivariate associated variables

**Multivariate Associated Variables

5.1.6.2. Obstetric, Attitude, Knowledge and other Related Factors Associated with Utilization of Skilled Birth Attendance in Ankasha Guagusa District, Awi Zone, Amhara region.

The next section depicted the association of obstetric and other related variables with skilled birth attendance utilization. Accordingly, age of marriage and birth were

highly risk factor for low utilization of skilled birth attendants only for bivariate analysis. i.e. the odds of women who were married less than 16years and give birth <20years were 71% and 69% times more likely utilized skilled birth attendance during labour than those who were married more than 16 and 20 years respectively even though the association was disappeared in multivariate analysis.

According to this study, number of antenatal follow-up during pregnancy and number of children ever born in her life time were two independent variables that affect maternal health care services utilization especially using skilled birth attendance during delivery. Women who had ANC visit more than four and above were COR= 6.78: 95%CI (2.87, 16.03) times more likely to utilized skilled birth attendance during delivery than those mothers below three ANC visits in their pregnancy follow up. Moreover, while other obstetric covariate was adjusted, the odds of mothers who had more than four ANC visits were AOR=12.96: 95%CI (3.20, 52.51) times highly went to modern health facility to be assisted by skilled health professionals than those mothers less or equal to three ANC visits. In case of parity, women who had less than four children in their life time were COR=3.05: 95%CI (1.63, 5.71) times more likely utilize skilled birth attendance during their parturition than those mothers who had more than four children in their life time. Hence, Parity had no significant association with dependant variable, if confounded with other related covariates.

Table 8 below indicated, mothers who encountered problems during delivery were the main independent predictor with skilled birth attendance utilization in both bivariate and multivariate analysis the odd of mother who encounter problem in both bivariate and multivariate analysis were COR=29.24: 95%CI (15.24, 58.27), AOR=61.97: %CI (19.83, 193.65) times more likely seek modern health facility than those normal once respectively.

Regards health service accessibility and availability, women who had been living in area near to the health post 87% less likely had got assistance of skilled birth attendance in their parturition time than those mothers living near to health center with COR= 0.13: 95%CI (0.07, 0.23). More over the odds of skilled birth attendance utilization were AOR= 0.17: 95%CI (0.04, 0.71) higher among mothers who had living near health center than mothers who had settled far from health center. According to this study results, distance of health facility was one independent

predictor to low coverage of utilization of skilled birth attendance during delivery to those mothers on the study district. Literally, women who got health facility more than 2 hours a walking distance were $COR= 9.99: 95\%CI (2.29, 43.48)$ times less likely went to modern health facility to be assisted by skilled professionals during their labour time than those mothers who settled equal or less than 1 hour a walking distance. When it was confounded the associations of distance of facility with dependant variable was vanished.

Moreover, women who had history of delivery in the health facility previously were $COR= 3.89: 95\%CI (2.25, 6.7)$ times went to health facility during labour compared to those mothers who had no history of giving birth at health facility previously. In multivariate analysis, previous history of giving birth at health facility had no effect on using skilled birth attendance during labour. This study result showed that, how knowledge and attitude associated with dependant variable.

The odd of skilled birth attendance utilization among women who had low knowledge about maternal health problem, pregnancy, and labour danger signs, birth preparedness and complication readiness were 64% less likely to be assisted by skilled professionals than those participants who were high knowledge ($COR=0.34: 95\%CI (0.20, 0.59)$). While other covariate was adjusted respondents' knowledge had no effect on use of skilled birth attendance. Moreover, mothers with unfavorable attitude towards maternal health services care related factors were $COR=0.25: 95\%CI (0.14, 0.44)$ times less likely attended by skilled professionals than those mothers with unfavorable attitude. Mothers with unfavorable attitude towards maternal health service questions were 65% less likely seek skilled birth attendance during their delivery than those respondents with unfavorable attitude while other obstetric and related factors were confounded.

Table 8: Obstetric and other Related Factors with Utilization of Skilled Birth Attendance among Mothers in Ankasha Guagusa Woreda, Awi Zone, North West Ethiopia, 2014

Variable	Skilled birth attendant		COR (95%CI)	AOR (95%CI)
	No %	Yes%		
Age at marriage				
≤16yrs	180(89.61)	21(10.4)	0.29(0.17, 0.51)*	0.86(0.24, 3.11)
>16yrs	3(71.5)	49(28.5)	1.00	1.00
Age at birth				
<20years	177(89.4)	21(10.6)	0.31(0.17, 0.53)*	0.65(0.19, 2.19)
>20years	126(72)	49(28.0)	1.00	1.00
No of ANC visit				
1 st visit	78(87.6)	11(12.4)	1.00	1.00
2 nd and 3 rd visit	121(80.1)	30(19.9)	1.76(0.83, 3.71)	2.06(0.68, 6.27)
4 th and above	23(51.1)	22 (48.9)	6.78(2.87, 16.03)*	12.96(3.20, 52.51)**
Parity				
<4 children	172(75.41)	56 (24.6)	3.05(1.63, 5.71)*	1.77(0.62, 5.05)
≥4 children	131(90.30)	14(9.7)	1.00	1.00
Complication during labour				
No	281(93.0)	21(7.0)	1.00	1.00
Yes	22(31.0)	49(69.0)	29.24(15.24, 58.2)*	61.97(19.83, 193.65)**
Type of HF				
Health center	49(53.8)	42(46.2)	0.13(0.07, 0.23)*	0.17(0.04, 0.71)**
Health post	254(90.1)	28(9.9)	1.00	1.00
How far HF				
<1hour	80(63.01)	47(37.0)	9.99 (2.29, 43.48)*	3.37(0.46, 24.64)
1-2hours	189(90.0)	21(10.0)	1.89(0.42, 8.43)	1.30(0.21, 8.22)
>2hours	34(94.4)	2(5.6)	1.00	1.00
Ever given birth at HF				
No	241(87.3)	35 (12.7)	1.00	1.00
Yes	62(63.9)	35 (36.1)	3.89(2.25, 6.71)*	0.82(0.29, 2.33)
Knowledge of mothers				
High	129(72.9)	48(27.1)	0.34(0.20, 0.59)*	1.69(0.65, 4.39)
Low	174(88.8))	22(11.2)	1.00	1.00
Attitude of mothers				
Favorable	116(69.9)	50(30.1)	0.25(0.14, 0.44)*	0.35(0.14, 0.88)**
Unfavorable	187(90.31)	20(9.7)	1.00	1.00

*Bivariate associated variables

**Multivariate Associated Variables

5.2 Qualitative Study Findings

Before starting to describe the qualitative findings, it is better to see how data were managed to start from selection of participants to data interpretation. With the help of the Woreda focal person and other key informants, adequate number of focus group discussants and in-depth interviewees were selected. Primarily, key informants who had more information and knowledge about maternal health services utilization from both men and women, especially participants who knew the reasons why majority of mothers give birth at home rather than health facility were contacted.

Overall, a total of 32 participants were teamed up into three focus group discussants. One group consisted of five religious and five elderly participants who were married with the age range of 36-66 years of age and the other group consisted of 11 married women discussants aged 20 or more years. The third focus group constituted 11 community leaders with age group 30 to 50 years. Each focus group discussion was conducted at different place. The discussion was moderated by the principal investigator with the help of a note taker.

Moreover, six in-depth interviews that comprised two health officers, one midwife, one clinical nurse, and two health extension workers from all clusters were taken and conducted. Most of the interviews were interviewed in their respective offices where in confidentiality of information and privacy of the interviewees can be maintained.

During the focus group discussion, all participants volunteered to participate and their voices recorded. Principal investigator played down dominant speakers to give an equal chance for each discussant. Each participant was encouraged to speak out their minds. First the audio information is transcribed in Amharic language which was then translated in English language using MS Word. The word test document was exported to Open Code software for coding and categorization. The translated document is read and re-read several times. Each line in the text in the Open Code software was given an appropriate code. The codes are then categorized. Categories are also assessed to form relevant themes for the research. Then thematic analysis was used to interpret the qualitative part of the research.

Table 9: Qualitative Data Analysis Procedures used in this study

Theme: Barriers towards skilled birth attendants' utilization among women in Ankasha Guagusa district, Awi Zone.			
Sub-Themes	Personal Barriers/Behavioral Barriers	Community related Barriers	Facility Related Barriers
Categories	-General Maternal Health Problem -Maternal Awareness, beliefs misconceptions, & misunderstanding -Women's autonomy	-Cultural & traditional practices(beliefs, misconceptions misunderstanding)	-Health Provider Related Barriers
Codes	-Disease workload -Beliefs, -Misconceptions -Misunderstanding -Low awareness, -Luck of privacy -Extreme shame -Less decision power...	-Misconceptions, -Beliefs -Misunderstanding -Cultural and traditional practices -Luck of knowledge...	-Attitude -Fear -Luck of Infrastructure (skill manpower...) -Shame -Awkward procedure - Misunderstanding...

5.2.1 Personal Barriers/Behavioral Barriers

5.2.1.1 General Maternal Health Problem

To start with general health condition of the mother, as most participants mentioned women had so many problems starting from pregnancy to delivery. During pregnancy mothers suffer with workload, repeated and unwanted pregnancy, precipitated labour, having many children, ante partum haemorrhage, heavy menstrual bleeding, food prohibition during pregnancy and inadequate intake of food that leads to different health problems for both the mother and the fetus. As most of the interviewees elaborated many pregnant women were not allowed to eat certain

food items, such as pumpkin, eggs, and some porteinous food during pregnancy. Particularly, pumpkin is believed to make the fetus very big in size as it was symbolized with the shape of pumpkin.

Additionally, inability and improper use of family planning methods exposed most mothers in the area to unwanted pregnancy and repeated pregnancy was the big issue to most of them. As a male participant age 30 years old raised, *“Now a days, we do not know the reason why our wives had twin babies when they got pregnant after continuous use of family planning methods, which is the main problem in our community”*. Moreover, heavy menstrual bleeding and accidental falling were also explained as common maternal problems. In the case of falling accident a woman aged 41 years said, *“once upon a time I think it might be on the third pregnancy, I fall. In that accident, both me and the child were hurt and the child was lost in my womb and the fetus comes out abnormally with face rotated to back, as health provider said to me”*. The other deadly problem of mothers in the community is ‘sereka’. ‘Sereka’ traditionally they believed that has three local names: retained placenta, ‘yhuala leje’ ‘Adefe’ which means loss of consciousness secondary to excessive vaginal bleeding after delivery it leads to both maternal and fetal death.

Another male participant aged 60 years explained i.e. ‘Sereka’, *“I had a fresh memory about a certain priest’s wife who died. In our culture, when a priest’s wife died, we can say she died two times, as firstly she is missed by her family, secondly her husband’s marital status will also be ruined as he could not re-marry to sustain his priesthood. The statuses of priests are not as easy as we think. These and other tragedies were averted, if health centers could be constructed nearby”*.

Prolonged labor was also another commonly recurring problem in the study district at which adequate infrastructure; especially road, ambulance, and skilled manpower were not available. It was also mentioned as the causes of many deaths for both mother and the fetus.

5.2.1.2 Low Awareness, Misconception, Misunderstanding and other related Barriers towards Skilled Birth Attendance

Client related factors basically include issues of disbeliefs, misconceptions and misunderstandings. Especially, women during pregnancy and delivery period had

shortages of awareness about the danger signs of pregnancy and delivery. Some participants revealed, *“we didn’t know the use of health facility delivery and other maternal health services previously.* Now days, there is some improvement and some information revealed from extension workers about maternal health service. Though much information was informed from different sources, we didn’t go and deliver at a health facility.

Rural women had many problems; they do not want to expose their bodies for anybody even their husbands. *“They said in health facility there is no privacy; a number of health providers could do awkward examination procedures that make us more scared and ashamed”. “But in our home no one can see us except a family member. Even, the family birth attendant did not see anything from us; expect receiving newborn baby and cutting the umbilical cord”.*

A female discussant mentioned that many women preferred to deliver at home in fear of exposing their bodies to an outsider and being visited and examined by a nearby relatives or family member. According to discussants there were misconceptions, beliefs and misunderstanding regarding skilled birth attendance. A female aged 39 years old explained that *“I did not want to go to a health facility to deliver because I could not put my husband’s pair of trousers under the pillow and sleep on it to facilitate my delivery.”*

On the other hand, a female health professional reiterated, in their district women are had deep rooted misconception towards them and health facilities not utilized effectively secondary to low awareness, mothers told us that they do not trust us because they think us as we tie their uterus not to give birth again, exchanging their newborn babies, expose the newborns to excessive light that makes their babies eyes squint and making their baby ‘wuffee’ by pulling their umbilicus inappropriately. Furthermore, many mothers need their baby’s nose straight by pinching and pulling upwards and correct their head to prevent frontal bossing and to become a circle and before bones get ossify. These and other practices were done when mothers delivered at home not at a health facility. Women’s privacy is also the other issue that forbade women going to health facilities. As a male participant mentioned *“Delivering at health facilities has been taken as a last option by pregnant women when the case was beyond the capacity of family and relative birth attendant.”*

5.2.1.3 Women Decision Making Power

Regards to women's autonomy some contradictory finding to the quantitative result was mentioned, though there was some improvement in the case of participating in some conferences. Most men do not believe the equality of women at all rounds. If we did that, we get a consequence, which they would undermine us, and cheat with another man, thirdly they do not want to rare our child, lastly maybe our marriage will dissolve. A male with age 66 years participants from one of the kebeles complemented that, *"during delivery time, most of the time only husbands had a great power in deciding where wives should deliver. In this case, husbands preferred wives to deliver at home without the interest of women. This is due to fearing of payment after referral for health service"*

5.2.2. Community related Barriers

5.2.2.1. Widespread Cultural and Traditional Practices, Beliefs Misconceptions, Myths and Misunderstanding during and after Delivery.

a. During delivery.

Cultural practices and beliefs such as the need to make coffee ceremony and having prayers of priests to conduct religious practices like reading religious books entitled *'Metsehafe Rufaele'* and *'Abune Zeraberuke'* are some of the reasons that makes mothers not to utilize the skilled birth attendance. The community had many non-useful beliefs concerning skilled birth attendance utilization; the majority of them believed that reading some religious books when a woman is labouring will give an immediate solution to labouring mothers. A man aged 38 years also mentioned that: *"when priests started to read these spiritual books like 'Metsehafe Rufaele' and 'Abune Zeraberuke' during delivery, they made the labour easy and smooth. These spiritual books are tested practically how to ease and facilitate labour. So our community believed in these spiritual books more than anything. "For me, if these books are available in my home, no need of going to health facility."*

A male FGD participant aged 50 mentioned that: *"If laboring women faced prolonged labor, we have traditional practice that should be done to facilitate labor which could not be performed at health facilities. First females start roasting coffee repeatedly by exchanging one another; if the women do not yet give birth to a child men would then*

substitute women to roast coffee to try their luck.” Another male FGD discussant aged 60 years old added: “In my life, I saw one woman whose labour stayed three days. But, when I started roasting coffee, she give birth immediately.” Hence, many people want me to roast coffee when their wives started labor by considering me as a luckiest person.” ‘ha, ha’ (he Loughs).

A female FGD participant aged 61 years re-iterated that: “In addition to coffee roasting, ‘abesh’ is important to be heard by St. Marry who facilitates smooth delivery. We all understand that, without the help of St. Marry nothing will be accomplished and there is a norm in this community that ‘Abesh’ is a cereal loved by St. Marry. Moreover, ‘Abesh’ is used for massaging the abdomen of the labouring mother after making dough out of it and painting on her abdomen’. In addition, during labour ‘Teleba’ was drank by labouring mother to soothe and relax her abdomen. But all of this custom and traditions that we practiced in our homes to smoothen delivery could not be performed in health facilities.”

A male FGD discussant aged 60 years old complemented that: “If women had prolonged labour, some members of the society had the belief and practice of carrying a kitchen hot stone called “Gulicha” by the back side of their head and saying “Egezio”. A male FGD discussant aged 50 years old added: “I didn’t remember in what order of my wife birth it occurs. Any ways, at one of my wife birth, I remember one elderly man who was burnt his back side of bold head with this hot stone ‘Gulicha” (laughing).

In addition, males and females were forced to disconnect their belts if the delivery is not smooth in our community. Closed household containers such as pots and other closed materials like closed container made from thread like material used for putting injera and cosmetic called ‘Agelegele’ and big container made from mud used for putting ‘teff’ and other cereal which is ‘Gota’ were also opened so that the labour could be facilitated. Moreover, a selected sheep which was rounded three times around the labouring mother’s head would either be slaughtered or allowed to stand in front of her to smoothen the delivery.”

“A male FGD participant aged 61 years old stated that: “when women deliver in our homes, we help them to sit on something to facilitate blood flow. We believed that if the blood did not come out, it would cause abdominal distension.”

b. After delivery

As most of participants explained in each step they do have their own cultural and traditional practices held after labour. *"After normal delivery, there is a custom of crushing pepper by stone, baking injera, and preparing porridge and slaughtering sheep even if the household is poor, unless she is not normal enough. In addition all above practices was done in respect to St Marry and to say goodbye and thank you!"* (Woman, age 30years old).

They also mentioned that when women faced 'sereka', they routinely immersed them in a big river. To prevent loss of consciousness and closeness of their mouth, women were also ordered to catch mirror in front of her face to see her face and not to close her eyes and *Maria Teresa* in between her teeth to prevent closure of her mouth. In addition, they started knocking tin, whipping whip, installing spear parallel to the pillar of the hut to prevent entrance of 'sereka' and firing gun near to her ear to make her weak up.

The family also had misconception of facilitating the removal of retained placenta with the help of traditional medicine and cultural practices such as sitting on hyena's leather and making women to squat on dry cow dug by the tip of her legs as it was informed by participants. They also claimed that 'adeke'/'yhuala leje' or retained placenta could get out from women's womb if a script from '*Melke Rufaele*' is read. if not removed after all practice, the traditional healers prepared traditional medicine which made from 'Dabakeded'+ 'Abalo' + straw together and crushed by stone and covered by pieces of clothes finally tied on the pregnant neck or hip in order that 'Adeke' or Yhuala leje were get out soon after baby were born(male age 59 years).

A 36 years old priest explained his history, *'my wife had to suffer with 'sereka'/loss of consciousness, starting from the 1st pregnancy. I made her to wear traditional medicine on her neck. After the drug tied on her neck, my wife had never develop sereka. But people who did not get this traditional medicine for their wife to sereka can start different practices as mentioned by other participants"*.

In related to placenta 'Yhuala leje', /'Adeke', the community had an intact belief not buried outside their home. Placenta is considered as a second child in their community. A certain FGD participant claimed that *"If the placenta was thrown*

away, the women would suffer from severe pain after delivery called 'Marate'. So, we buried the placenta inside home near to one side of the wall of the house that is dug by husband's left hand with a spear."

A male FGD participant aged 37 years mentioned that *"Labouring women were not allowed to go out their homes before they were baptized using holy water to protect them from an evil spirit. Labouring mothers are not allowed to cross a river in fear of bringing heavy and snowy rain for the community. All of these beliefs could not be performed in a health facility which made us to shy away from modern delivery care."*

Some participants also informed about their misconceptions of allowing the postnatal mothers to drink excessive local drink 'Areki'. This leads some postnatal women for fatal death.

In delivery related cases, some believed that they would not get the diseased mothers if the women died after being referred.

5.2.3 Facility related Barriers

As we observed three health centres and the other health post from each Kebele, except the two urban health centres which had better infrastructure, the rest one health center, which constructed 20km away to nearest urban health center i.e. Degra had no any adequate furniture's in it. There was only a building with no road network, water, light, even temporarily resting bed and other instrument like protective devices like gynaecological glove and so on. One participant said from Dengusha kebele.

"To me, the nearby health center is a barren building. When I say this, I am not extremely criticizing the government. But as much possible, the government should equip it with essential materials and staff it with adequate number of manpower that are committed to work and help all patient and client. Otherwise, leave alone providing adequate care for laboring mother, we do not expect the constructed health facility and assigned health personnel's to save our lives from simple curable diseases'. As such many labouring women decided and boldly said that our home had better care than health facilities in our neighborhood" (Male 39 years old)

They also added that there is no adequate infrastructure including light, water, waiting room, bed, and different type of drugs. No road to the health facilities and

there is no ambulance service. These problems were worsening during winter because of the presence of the big rivers in each Kebles. *To save our lives and the lives of mothers we went to private clinic to get better treatment and instrument. Private clinic did not consider our problem. They forced us to pay at least 400 birr per visit whether we get treated or not for simple procedures which could be done in our health centers if there were simple devices and instruments. This payment is not easy for the poor in our community.*

A 27 years old health professional explained that, *"in our health center, there is even no water which is very important and essential for everything. you can imagine without water how can we manage labouring women, do even clean delivery, there is no light, without light most laboratory investigations could not be done and we did not do sterilization technique for delivery sets. Now a days, we have to be careful not contaminate us and our clients/ patients with blood born disease. But in our health center that could not be maintained even for ourselves. Another amazing fact is that what I tell you is (laughing) there is no delivery coach in this health facility leave alone waiting room. You can imagine without delivery couch it is difficult to assist the labouring mothers. We simply assist our labouring mothers with antenatal coach which is broken and had cracking sound. This cracking sound disturbs not only our clients; we are also scared of not drop the new baby and labouring mothers. You can assume this facility were constructed three years back so how can labouring women come and give birth in this facility. Government proclaimed that no one woman could die while she gave life. But this slogan did not include rural residents."*

Concerning payments for getting health services including delivery service, participants revealed that although the payment is free, accountants were not committed to give them back their changes. They informed that getting a new diagnosis card was not simple.

5.2.3.1 Health Provider related Barriers towards Utilization Skilled Birth Attendance

Regarding the health provider's attitude towards laboring mothers, there were many malpractices starting from the security guard to other health professionals. For example, the guard forbade us to enter the health facility at night; health providers isolate family members of labouring mothers. They did not give a sound service in a

transparent and ethical manner. A certain male discussant expressed the context as *"They considered themselves as 'God'."*

45 years old priest discussant mentioned, *"Health professionals working in health facilities were not that much skilful even in treating malaria. The workers did not listen to us. They quarrel and disrespect one another"*. Another male aged 38 years old complemented, *"once up on a time, I was there accompanying my sister what I see was most of health providers were careless, simply went here and there by wearing attracting clothes. They did not do anything to save our lives. Of course I was not blaming all, but there were few health providers who were interested to help patients day and night"*.

Moreover, health providers were generally criticized for their preferential approaches and services for urban dwellers and their relatives rather than serving neutrally for every client coming to the health facility. They were not skilled, too committed and able to give adequate health services. Health providers did not also have adequate awareness to teach the community. In addition to this, some participants mentioned that in most health facilities there is no enough skilled manpower and mistrust to most health professionals especially extension workers.

'A 39years old male participant explained about extension workers; "Health professionals must be qualified and should have adequate skills to manage pregnant and labouring mothers, but community health extension works had taken health trainings for only 9 months. Therefore, with this educational level how could they treat pregnant and labouring mothers? What kind of mother will come to them to deliver with their assistance? Of course, most pregnant mothers had their antenatal follow up in health posts. But, I do not think labouring mother will give birth at this health posts, unless other better trained health professionals are assigned. Generally, I felt that all health professionals including, health professionals assigned in the nearby health center, have no adequate knowledge and skill to manage our labouring mothers and save their lives".

On the other hand, some in-depth interviewees said, the main cause for low utilization of skilled birth attendance was related to health provider's commitment. A male health professional who is 38 years old added that, *"As I observed, most health providers simply think about their monthly salary rather than to help and create*

awareness to mothers to increase level of maternal health care services especially skilled birth attendance during labour. One midwife gets only 900 birr per month which does not cover household needs. The on duty payment for one midwifery, who assisted more than 35 labouring mothers in some instances, is only 35 birr per night. So I did not think this payment is fair for skilled health providers. As you know, assisting delivery service is not an easy task. While you are helping labouring mother you may endanger your life. To mean that when one laboring mother deliver in front of you before she reach to delivery coach you may be obliged to assist her with bare hand. So there must be complementary payment to motivate health workers. Such and others things affect health providers not to go through the grass root level community to create awareness”

6. DISCUSSION

Mothers who were assisted by skilled birth attendant during delivery were only 70(18.8%). The skilled birth attendance prevalence was 42 (46.2%) among urban residents and 28(9.9%) among those living in rural areas. Urban prevalence of skilled birth attendance documented by this study findings were consistent with the finding in North Showa Zone and EDHS 2011(8, 20). But, the proportion of delivery assisted by skilled birth attendance in rural residents was somewhat higher than the research done in Metkel Zone, Wolediya, Baseline Household Survey report and EDHS 2011(8, 25, 34). In addition to this, the overall prevalence for the study district were somewhat similar with the studies done in North Showa and Kembatta-Tembaro Zone but, higher than the studies done in Metekel Zone and Sekela District(20, 25, 35, 36). The reason for this difference might be attributed to the fact that the two surveys were conducted in different times and more advocacies are done in recent years.

According to this result, respondents' place of residence had significant association with skilled birth attendant utilization. Mothers who resided in urban areas were more likely to be attained by skilled professionals compared to their counterparts. This finding was consistent with other research findings reported in Ethiopia(20, 37, 38) The difference may be due to the increased availability of health services and other infrastructure such as shorter distance to health facilities, better roads and transportation, more information education in urban than rural areas. This is further augmented by the qualitative finding as most of interviewees and discussants complemented reasons for low utilizations of skilled birth attendance among rural mothers due to widely distributed beliefs, cultural and traditional practices, misconceptions, and misunderstandings.

Educational status of mothers was also significantly associated with the utilization of skilled birth attendants. Mothers who attained secondary and above educational level were AOR=6.27: 95%CI (1.31, 30.05) times more likely to utilize skilled birth attendant than those mothers who were unable to read and write. This finding was in line with other studies that were done in Sheka, Arsi, Metekel, Sekela, North Shewa Zones and other developing countries(20, 25, 36, 38). The reason could be educated women had access to written information and could adapt to modern cultural

perspectives. Moreover, education empowers females so as to increase autonomy and self confidence to make capable for decision making about their own and their families' health. With regards to educational status, qualitative study participants indicated that educational status is the only thing that plays great difference between rural residents and urbanites (Male, health professional, 25 years old).

Almost all rural people are none educated, though some had changed their behaviours through community health extension workers. Majority of them still did not change with their primitive perspectives. Especially none educated women had dozen of problems. They lack confidence, and are scared, and they did not know pros and cons of maternal health care services, they are highly manipulated by community based cultural practices, beliefs, had deep rooted misconception, myths and misunderstanding. Generally non educated mothers and other community members had all-rounded disadvantageous as documented in researches done in different part of Ethiopia and other countries. *"due to this back ward thinking and misconceptions labouring women were not allowed to go out their homes before they were baptized using holy water to protect them from an evil spirit. Labouring mothers are not allowed to cross a river in fear of bringing heavy and snowy rain for the community. All of these beliefs could not be performed in a health facility which made us to shy away from modern delivery care."* (A male FGD participant aged 37 years). *Similar findings were documented in other studies(38, 39).*

Frequency of ANC visit during the last pregnancy was also found to be a strong predictor of utilization of skilled birth attendance when confounding factors were controlled. Those women who had four and above visits were AOR=12.96: 95%CI: (3.20, 52.51) times more likely to deliver in the assistance of skilled professionals than those mothers who had less than two ANC visits. This finding was consistent with studies done in developing countries including, North Wollo Wolediya, North Ethiopia Mekle, Tanzania and Cambodia (9, 29, 34, 40). This may be due to the fact that as the number of ANC visits increase, the more likely women will be acquainted with basic information on pregnancy and delivery related risks that require providers' intervention.

This study also showed that mothers living near to health post were less likely to deliver with the assistance of skilled birth attendants than mothers living nearby the

health center. This result was in line with research done in different countries(9, 29, 40, 41). This could be because of the fact that mothers living near to health posts were mostly rural mothers who are not educated which had non enhanced understanding related to pregnancy and delivery related risks and complications tied with many cultural and traditional practices misconceptions, misunderstandings. This finding was consistent with some studies done in Ethiopia and Nepal(13, 21).

Finding from qualitative observation complements, shortage of infrastructure, type of health facility had direct effect to skilled birth attendance prevalence in the study district, though numbers of constructed health facility were increased averagely in rural area, these facilities were not equipped with adequate infrastructure compared to urban health centre(25, 35). A male participant aged 39 years old said from one kebele - *“as for me nearby health center was simply standing constructed building. When I say this I am not extremely blaming the government. But as much as possible the government should fulfill essential infrastructure, like, light, water, delivery coach, road, ambulance and manpower that are committed to work and help all patient and labouring and pregnant mothers like that of urban health centre. Unless not only laboring mother who give as natural phenomena, we did not expect constructed health facility and assigned health personnel's save our life's while we were critically ill”. In order that, many labouring women prefer delivery at their home than health facility ”.*

As one urban senior health professional try to reiterated, *“Due to mal distribution of infrastructure, topography, and other barriers we still doing nothing to our mothers to save their lives, I had one memory in my working experience, one obstructed labouring women told that, I come to this facility surely to be assisted by skilled professionals, and to return to my home with my baby but not to be referred or lost my child. But you referred me and my child was lost in my womb, why this could be happened? Why do not you help me? She asked. You can imagine this woman came from too far distance with obstructed labour; I was faced with many mothers with a problem. As you know obstructed labour results rupture of uterus if she was not treated soon. So many women were died with this case after or before referred them. This catastrophic case for mothers and their new baby was averted, if at least one Emergency obstetric care services will constructed at zonal level”.* This finding results were in line with articles done in different countries(13)

Another important finding of this study was that mothers who didn't face any health related problem during labour and delivery were AOR=61.97:95%CI (19.83, 193.65) times less likely gave birth at health facility compared to those mothers who faced one of maternal complication. This implies that labouring mothers gave birth in health facilities and use skilled birth attendant while they faced difficulties and when home repeated trials failed.

Similar results were obtained from studies done in Sekela, North Shewa, and Agemssa, Wollega, Zone (20, 25, 37). As a male participant elaborated "Delivering at health facilities has been taken as a last option by pregnant women when the case was beyond the capacity of family and relative birth attendant." many labouring women did not want to give birth at health facility. Because of, need of privacy, extreme fear, shame, health providers awkward procedure and related cases were obstacle not to seek skilled birth attendance. This finding was in line with other researchers conducted at the earlier times (7, 37, 40).

Attitude of mothers about pregnancy and delivery related services, pregnancy and labour complications were found to be significantly associated with delivery services utilization by skilled birth attendants. This finding was in line with the study done in North Shewa, West Gojjam, in Metekel Zone, and Tanzania (20, 25, 29) who documented that mothers who had favorable attitude towards pregnancy problems and management of labour and delivery were AOR= 2.82:95%CI(1.13, 7.04) more likely to use skilled birth attendant during delivery than mothers who had unfavorable attitude . This is further augmented by the qualitative findings in this study which showed that the role of Health Extension Workers to enhance skilled birth attendance was minimal. For instance one of the FGD discussant highlighted that *"we did not trust health extension works because of their educational level. They had taken only 9 months therefore with in this educational level how they were treat pregnant and labouring mothers. But I do not think so labouring mother will give birth at this health post unless other professionals will assigned. Generally what I conclude for all health professionals no one had adequate knowledge and skill to manage our labouring mother and to save our life including health professionals found in near health center"*.

This finding was witnessed that Community health extensions workers and other responsible stakeholders did not create awareness through education information communication to the community to change their knowledge and attitude and health extension workers did not show practically and confidentially managing normal labouring mother is so easy in their health post.

7. STRENGTHS

- Assessed both user and provide aspects of skilled birth utilization by different tools and methods
- Different study methods were employed to triangulate the data.
- This a community based study conducted in a remote community

8. LIMITATIONS OF THE STUDY

Although the study had a number of strengths, there were also some limitations

- Since the data collectors were health professionals there may be professional bias even though a great effort was made to minimize it during the training and data collection period.
- Had all the limitation of a cross-sectional study

9. CONCLUSION

- Generally utilization of skilled birth attendant level in the study area was very low (18.8%) with a much lower rate in rural areas (9.9%).
- Mothers in urban areas, in secondary and above level of education and visited ANC 4 or more times were positive association with skilled birth attendant utilization. On the contrary, mothers living closer to health posts, unfavourable attitude towards maternal health services, mothers who hadn't problems during labour and delivery were less likely to use skilled professionals during their parturition time.
- The main barriers to utilize skilled birth attendant in the study area were wrong beliefs, misconception, cultural and traditional practice, to make home like environment such as the need to make coffee ceremony, porridge and having prayers by priests to conduct religious practices like reading religious books during delivery time, moreover having traditional medicine and practices for removal of placenta and loss of conscious called 'sereka' and to fear of thrown away placenta which considered as second child are some of the reasons practiced during delivery that makes mothers not to utilize the skilled birth attendance.

10.RECOMMENDATIONS

- The government should build health centres at a closer distance and equip necessary supplies for better service Quality to mothers in rural communities.
- Health Extension Workers should consistently counsel pregnant mothers to attend their antenatal follow-up during all months of pregnancy
- Health extension workers should intensively educate pregnant mothers on risks associated with pregnancy and delivery
- The government should enhance secondary and above level of education in rural communities
- Intensive awareness creation should be made to change the negative attitude of mothers towards preventability of labour and delivery complication,
- More attention should be given to widely distributed beliefs, cultural and traditional practices, misconceptions and misunderstandings.
- Basic emergency obstetric care service should be availed in health centres and primary hospitals at woreda capitals.
- Trained, motivated and competent skilled birth attendants should be assigned and available in rural health centres and Health posts in a sustainable way.

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12. ANNEXES

12.1 Annex One: English Version Questionnaire for the Quantitative Study

Study Questioner Prepared on Prevalence, Barriers, Misconceptions, Myths and other Related Reasons/Problems of Delivery Care towards Skilled Birth Attendance among Women of Reproductive Age Group Residing in Ankasha Guagusa woreda who Gave Birth in the Past Twelve Months.

i. Information Sheet:-

Good morning/afternoon dear participant. My name is ----- . I am working as data collector on behalf of misses Mulunesh Alemayehu in a survey conducted for the partial fulfilment of Masters Degree in Public Health in Addis Ababa University. The purpose of the study is to explore prevalence, barriers, myths and misconceptions towards skilled birth attendant among women of child bearing age in this district area, in scientifically sampled kebeles. As part of this survey we are collecting your information on socio-demographic, obstetric, knowledge and attitude about pregnancy risk, and health service utilization and others which are obstacle to use the service.

The information in this questionnaire will be kept strictly confidential, will not be divulged to any one and only the research group will have access to the information you gave but your name and address will not be recorded or identified even by the research team. However you have a right to interrupt your participation at any time or you can answer some questions you like to do so. The interview will take 30-45 minutes. I will appreciate and respect what so ever your decision will be. Thus, this questionnaire will be filled only if you agree to take part in the study and I sincerely ask you to give your genuine and true responses to the questions provided.

For further information you can contact with principal investigator misses Mulunesh Alemayehu by Mobile No: 0918783371; Email: mulu2019@gmail.com

ii. Consent Form

I, the interviewee, understand aims of what is to be studied. Hence, in order to make a decision to participate in the research as follows:

1. Yes
2. No

If you are volunteer to participate you can start the questioner

PART ZERO: IDENTIFICATION PARTICULARS

Q001. Questionnaire code _____

Q002. Name of the kebele _____

Q003. Name of data collector _____ Code _____

Q004. Name of supervisor _____ Code _____

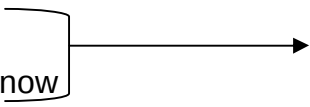
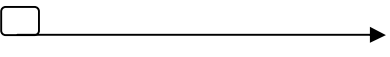
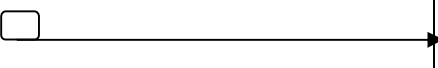
Q005. Date of interview in Ethiopian Calendar -----/-----/-----

Q006. Result of interview: 1. Completed 2. Respondent not available

3. Refused. 4. Partially completed

PART I: RESPONDENT'S SOCIO-DEMOGRAPHIC

Q. No	Questionnaire on identification	Alternative choice for responses	Skip
101	Type of usual place of residence	1. Urban 2. Rural	
102	How long have you lived in this kebele?	Duration in: Year ____ month ____	
103	How old were you at your last birthday in completed years?	----- years	
104	What is your religion?	1. Orthodox 2. Muslim 3. Protestants 4. Others-----	
105	What is your ethnicity?	1. Amhara 2. Agew 3. Oromo 4 Tigre 9. other, specify-----	
106	What is your marital status	1. Married 2. Single 3. Divorced 4. Separated 5. Widowed	Go to 109

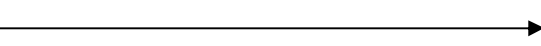
107	Do your husband /partner have other wives or does he live with other women as if married?	1. Yes 2. No 3. Don't know		Go to 109
108	If your answer for No 107 is Yes, Are you the first/ second wife?	Rank of wife-----		
109	Can you read and write simple sentences in any language you speak?	1. Yes 0 No ☐		Skip to 111
110	What is the highest attained level of education	Informal_____(Put an "X") ----- Grade		
111	Can your husband/start living as husband and wife) read and write simple sentences in any language he speak?	1. Yes 0. No ☐		skip to } 113 (married only)
112	What is his the highest attained level of education	Informal_____(Put an "X") -----grade		
113	What is your main Occupation?	1. Farmer 2. Government employee 3. Private employee 4. Handcrafts 5. Daily labourers 6. House wife 7. Merchant 8. Student 9. Other specify-----		
114	What is your husband's(start living as husband and wife) main occupation	1. Farmer 2. Governmental employee 3. Private employee 4. Handcrafts 5. Daily labourer. 6. Merchant 7. Guard		For married only

		8. student 9. Others -----	
115	How many are the usual size of member of your households?	_____ household size	
116	Who usually makes decisions about making major household purchases?	1 Myself 2 My Husband 3 Elder families 4 Both 9 Other specify-----	
117	What is the average family income per months? (Each kind of house hold income should be recorded by calculating with current market price)	-----Birr	

PART II:-RESPONDENTS OBSTETRIC HISTORY

No	Questionnaire on	Alternative choice for Responses	Skip
201	How old were you in your last birthday when you got married for the first time?	----- in completed years?	
202	How old were you in your last birthday when you got pregnant for the first time?	-----in completed years?	
203	How old were you in your last birthday when you had first birth?	-----in completed years?	
204	How many sons and daughters do you give birth to and are alive and live with you?	1. Boys alive --- 2. Girls alive--- 3. Total alive----	
205	How many sons and daughters	1. Sons elsewhere----- 2. Daughters elsewhere---	

	are alive but do not live with you?	3. Total children elsewhere-----	
206	How many boys and girls have died?	1. Boys died ----- 2. Girls died----- 3. Total died children-----	
207	How many children have you ever given birth to in your life time?	1. Boys ever born ----- 2. Girls ever born---- 3. Total children ever born-----	
208	Did you receive antenatal care in your last pregnancy?	1. Yes 0 No ☐ →	Go to 212
209	If yes. How many times did you receive antenatal care during last pregnancy?	----- number of visit 99 I don't remember ☐ →	Skip to 212
210	At what gestational age you start antenatal follow up in your last pregnancy?	----- months 99 I Don't remember ☐ →	Skip to 212
211	Whom did you see during your antenatal visit?	1. Physician 2. Health officer 3. Midwife/ Nurse 4. Health extension workers 9 other (specify)-----	
212	Where did you give birth to the last child?	1. In my home 2. Other's home 3. Hospital 4. Health centre 5. Private clinic 9 Other(specify)_____	Skip to 214

213	Why didn't you deliver in a health facility? (Multiple answers are possible)	1. Facility too far 2. Too much cost of Health facility 3. Facility not open regularly 4. I feel most comfortable in my home 5. Presence of traditional birth attendants 6. bad outcome with previous deliveries at health facility 7. No female provider at Health facility 8. Due to parents preferences 9. Other(specify)-----	
214	If your answer is health facility, Why did you prefer to deliver at a Health facility? (Ask for those delivered at health institutions). (Multiple answers possible)	1. Harmful traditional practice can be avoided(massaging, herbs) 2. Previous better outcome for me and my child by giving birth at health facility 3. Health facility was near to me 4. Bad outcome with previous home delivery 5. I was advised to deliver at health facilities 6. To lower maternal exhaustion during labor 7. Lower maternal postpartum pain 9 Others (specify)-----	
215	If your answer is in the health facility, Who assisted the delivery of last child birth?	1. Health personnel (doctor, health officer, nurses, midwife...) 2. Health extension workers 9 Others (specify)-----	
216	What was the mode of your last delivery?	1. Spontaneous vaginal delivery 2. Instrumental delivery 3. cesarean section 4. I do not remember	
217	Had you come across any health problems during labor, delivery and immediately after birth during your last delivery?	1. Yes 0 No ☐ 	Skip to 301

218	If yes, what were the problems? (Multiple Answers Possible)	1. Vaginal bleeding 2. Swelling of leg/face 2. Severe head ache 3. Blurring of vision 4. Reduced/absence of fetal movement 5. Severe abdominal cramp 6. Excessive weight gain 7. High grade fever 9 Other(specify)-----	
219	What measures were taken to alleviate the problem? (Multiple Answers Possible)	1. Taken to health facility 2. Consulted trained delivery attendant 3. Took traditional medicine 4. No action taken 9 Other(specify)-----	

PART III: - RESPONDENTS KNOWLEDGE AND ATTITUDE TOWARDS SKILLED DELIVERY ATTENDANT.

301	Do you know any health risks a woman might experience during pregnancy?	1. Yes 0 No ☐ →	Skip to 303
302	If yes what are those risks? (Multiple answers possible)	1. Pregnancy related problems 2. Fetal death 3. Maternal death 9 Other, specify_____	
303	Do you know any danger signs woman might experience during pregnancy?	1. Yes 0. No ☐ →	Skip to 305

304	If you say yes for No “303”, what are the danger signs? (Multiple answers are possible)	1. Vaginal bleeding 2. Swelling of leg/face 3. Severe head ache 4. Blurring of vision 5. Reduced/absence of fetal movement 6. Severe abdominal cramp 7. Excessive weight gain 8. Fever 9. Other _____	
305	Do you anything about the presence of birth preparedness and complication readiness plan during pregnancy?	1. Yes 2. No ☐ 3. I don't know ☐	Skip to 307
306	If you know what are they? (More than one answer is possible)	1. Identify place of delivery 2. Preparing essential items for clean delivery & postpartum period 3. Identify skilled provider 4. Identifying danger signs 5. Identifying better and nearest health services facility 6. Designating decision maker on her behalf 7. Arranging a way for communication transportation 8. Saving money for emergency cases 9. Arranging blood donors 9 Specify others-----	
307	Do you know any danger signs of labour?	1. Yes 0. No ☐	Skip to 308

308	If yes, what are the danger signs? (Multiple responses are possible)	1. Prolonged labor greater than 12hrs 2. Early rupture of membrane 3. Mal-presentation 4. Convulsion 5. vaginal bleeding 6. Placenta retention >1hr 7. Increased Blood Pressure 8. Cessation of labor pain 9. Other, specify----	
From the following expressed idea I want you to respond your agreement or disagreement by choosing alternative answers: Strongly disagree, Disagree, Not sure, Agree, Strongly agree			
309	Majority of complications that are happen during labor are preventable and treatable?	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	
310	Like any women I could be at risk for health problems related to delivery	1 Strongly disagree 2 Disagree 3 Not sure 4 Agree 5 Strongly agree	
311	like any pregnant women, I am the one who was susceptible to face delivery complications	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	
312	Delivery complications can be severe and may be hazardous to me and my new born.	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	

313	Being attended by a skilled delivery attendant may be beneficial to my baby and my wellbeing.	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	
314	Health professionals in the nearest health facility have the appropriate skill to detect and treat or refer delivery complications?	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	
315	Health facilities in nearby are staffed with skilled professionals to provide delivery service.	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	
316	A pregnant mother who has no health problem is not necessary to go and give birth at health facility	1. Strongly disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree	

Part IV: Health facility related factors (Availability, Accessibility of services) among respondents

401	Is there any nearby Health facility in your kebele?	1. Yes 0 No	
402	If you say yes, How long does it take to go the nearest health facility?	_____day/s -----hours -----Minutes	
403	What type of health facility is it?	1. Health post 2. Clinic(private)	

		3. Health centre 4. Hospital 9 other specify_____	
404	What type of services did you get from it so far? (Multiple Answers Possible)	1. Antenatal care 2. Delivery service 3. Family planning 4. Postnatal 5. Immunization 6. Curative services 9 Other specify-----	
405	Have you ever given births at health facility?	1. Yes 0. No ☐ 	Skip to 409
406	If you say yes, how did you receive the service from this facility?	1 Free of charge 2 On payment basis 3 I do not remember	
407	What was your opinion on the Payment?	1. Cheap 2. Fair 3. Unaffordable 4. I have no suggestion	
408	Were you able to pay for the services?	1. Yes 0 No	
409	What is Delivery service Provider attitude toward laboring women?	1. Very poor 2. Poor 3. Satisfactory 4. Good 5. Very good	
410	Do you have any information about the benefit of delivery in health institution?	1. Yes 0. No	
411	If yes what is the primary source of information?	1. Health workers 2. Friends, neighbours... 3. Radio, TV...	

PART V. COMMUNITY RELATED BARRIERS TOWARDS SBA

No	Questionnaire	Alternative choice for Responses	Skip
501	What is your husband attitude towards institutional delivery?	1. Very poor 2. Poor 3. Satisfactory 4. Good 5. Very good	
502	What are reasons for husband's negative attitude towards institutional delivery? (Multiple Answers Possible)	1. They kill time 2. unfair and expensive price 2. Unable to perform cultural ceremonies 3. Unpleasant approach of health workers 4. other specify-----	
503	What is your family's preference towards delivery attendant?	1. Health personnel's(doctor, health officer, wide wife/nurse) 2. Traditional birth attendant 3. Community health extension 9 Others (specify)-----	
504	Do you think birth attendant in nearby health institution are highly recognized and trusted by the community?	1 Yes 0 No	
505	Is there any traditional medicine done to the mother during child birth at home?	1 Yes 0 No	
506	What is the reason for medication?	1. To hasten child birth 2. To prevent complication 3. To relief pain 9 Other specify-----	

507	If you want money for health service, from where did you get money?	1. I have enough money to pay 2. My family 3. Relatives 4. Both 9 Other people, Specify	
-----	--	---	--

THANK YOU!!

12.2 አባሪ ሁለት፡ በአማረኛ የተተረጎመ መጠይቅ

በአንክሻ ጓጉሳ ወረዳ በዚህ አንድ አመት ውስጥ ምን ያህል ነፍሰጡር እናቶች በስለጠነ የጤና ባለሙያ እንደወልዱ፣ ነፍሰጡር እናቶች በወሊድ ጊዜ የስለጠነ ባለሙያን እንዳይጠቀሙ ስለከለከሏቸው እንቅፋቶች፣ የተሰሳቱ አመለካከቶች፣ አሉባልታዎችና ሌሎች ያልታወቁ ምክኒያቶች ጋር ስለተያያዙ ሁኔታዎች ለማጥናት የተዘጋጀ መጠይቅ

i. የመረጃ ቅጽ፡-

ጤና ይስጥልኝ እንደምን አሉ ወድ ተሳታፊ? ስሜ -----ይባላል፡፡ በአዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና ትምህርት ቤት የድህረ ምረቃ ተማሪ የሆኑት ወ/ሮ ሙሉነሽ አለማየሁ የምረቃ ማሟያ የሚሆን ጥናት በሳይንሳዊ ዘዴ በተመረጡ ቀበሌዎችና ቤቶች ላይ መረጃ በመሰብሰብ ላይ እገኛለሁ፡፡ የጥናቱ አላማ በአንክሻ ጓጉሳ ወረዳ ምን ያህል ነፍሰጡር እናቶች በስለጠነ የጤና ባለሙያ እንደወልዱ፣ ነፍሰጡር እናቶች በወሊድ ጊዜ የስለጠነ ባለሙያን እንዳይጠቀሙ ስለሚያደረጉ እንቅፋቶች፣ የተሰሳቱ አመለካከቶች፣ አሉባልታዎችና ሌሎች ያልታወቁ ምክኒያቶች ላይ ያተኩራል፡፡ ለዚህ ጥናት ይረዳ ዘንድ የርስዎን ማህበራዊና የህይወት ታሪክዎን የሚዳስሱ፣ በእርግዝናና ወሊድ ጊዜ ስለሚከሰቱ ችግሮች ያለዎትን እውቀትና ግንዛቤ፣ የጤና ተቋም አገልግሎት አስጣጥንና በሌሎች ጉዳዮች ላይ ችግሮችን ለመለየት መረጃዎችን እየሰበሰብን ነው፡፡ በመሆኑም የሚሰጡን መረጃ መንግስትና ሌሎች ጉዳዩ የሚመለከታቸው አካላት የእናቶችን ወሊድ አገልግሎት አጠቃቀም ለማሻሻል የመፍትሄ መንገዶችን እንዲቀይሱ ይረዳቸዋል፡፡ ስለዚህ በጥናቱ ላይ መሳተፍ ያለመሳተፍ ውሳኔዎ የተከበረ ነው፡፡ በምንሰበስባቸው መረጃዎች ላይ ስምዎት ስለማይመዘገብና ሌሎችም መለያ መረጃዎች በሚስጥር ስለሚጠበቁ ስጋት አይግባዎት፡፡ ቃለመጠይቁን መሙላት የምጀምረው ፈቃደኛ ሲሆኑ ብቻ ነው፡፡ ፈቃደኛ ከሆኑ አጥብቄ ከልብ የምጠይቀዎ መልሶ ገንቢና እውነተኛ ምላሽ እንዲሆን ነው፡፡ ቃለ መጠይቁ ከ30-45 ደቂቃች ያህል የሚወስድ ሲሆን በማንኛውም ጊዜ ማቆም ይችላሉ፡፡ እስካሁን በተነጋገርናቸውና ባነበብኳቸው ጉዳዮች ላይ ያልገባዎትና ግልፅ ያልሆነ ነገር ካለ መጠየቅ ይችላሉ፡፡ ለማንኛውም ወሳኔዎ አመሰግነዎታለሁ፡፡

ከእኔ አቅም በላይ የሆነውን ደግሞ የጥናቱ ዋና ባለቤት ወ/ሮ ሙሉነሽ አለማየሁን በስልክ ቁጥር 0918783371 ያነጋግራሉ ወይም email mulu2019@gmail.com ሊጽፉላቸው ይችላሉ፡፡

ii. የስምምነት ቅጽ

አሁን የጥናቱን አላማ በደንብ በሚገባኝ ቋንቋ ስለተረዳሁ የተሳተፊነት ውሳኔየን በዚህ መልኩ አረጋግጣለሁ፡፡

1. አዎ ፈቃደኛ ነኝ

2. ፈቃደኛ አይደለሁም
- ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ

ከፍል ዜሮ፡- የአካባቢዉ መለያ፡-

ቁ001-የመጠይቁ ኮድ _____

ቁ002- ቀበሌ _____

ቁ003-የመረጃ ሰብሳቢዉ ስም _____ ኮድ _____

ቁ004- የበላይ ተቆጣጣሪው ስም _____ ከድ _____

ቁ005- መጠይቁ የተካሄደበት ቀን _____ / _____ / _____

ቁ006- የወይይቱ ውጤት 1. ተጠናቋል 2. በከፊል ተጠናቋል 3. ተሳታፊዎች አልተገኙም. 4. ለመሳተፍ ፈቃደኛ አይደለም

ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ

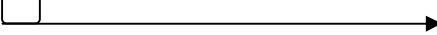
ክፍል አንድ፤ ማህበራዊና ሰነ-ህዝባዊ ባህሪያት ጉዳዮችን የሚዳስሱ መጠይቆች

ተ.ቁ	መጠይቅ	ምላሽ	ወደ ተ. ቁ
101	የሚኖሩበት ቦታ አይነት?	1. ገጠር 2. ከተማ	
102	ለምን ያህል ጊዜ እዚህ ቀበሌ ኖሩ	-----	
103	የመጨረሻ ልደተዎን ሲያከብሩ እድሜዎ በሙሉ ዓመት ስንት ነበር?	-----አመት	
104	የየትኛው ሀይማኖት ተከታይ ነዎት?	1 አርቶዶክስ 2 እስልምና 3 ፕሮቴስታንት 9. ሌላ (ይጠቀስ)-----	
105	የየትኛው ብሔረሰብ/ብሔር አባል ነዎት?	1. አማራ 2. አገዳ 3. አሮሞ 4. ትግሬ 9. ሌላ ካለ (ይጠቀስ)-----	
106	በአሁኑ ወቅት የጋብቻ ሁኔታዎ ምንድን ነው?	1. ያገባች አብረው የሚኖሩ 2. አግብታ የማታወቅ 3. አግብታ የፈታች 4. አግብታ ተለያይተው የሚኖሩ 5. ባሏ የሞተባት	ካሉ ወደ 109 ይለፉ
107	የባለቤትነት/የጓደኛነት (እነደ ባልና ሚስት አብረውት የሚኖሩት ወንድ) ከእርስዎ ሌላ ሚስት አላችኋል?	1 አዎ 0 የለም ☐	ካሉ ወደ 109 ይለፉ

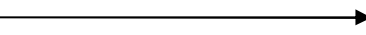
108	ለጥያቄ ቁጥር “107” መለስዎ አዎ ከሆነ እርስዎ ስንተኛ ሚስት ነዎት?	-----በቅደም ተከተል	
109	እርስዎ ቀለል ያሉ ጽሁፎችን በሚናገሩት ቋንቋ ማንበብና መጻፍ ይችላሉ?	1 አዎ 0 የለም ☐	ካሉ ወደ 111 ይለፉ
110	የመጨረሻ ያጠናቀቁት ክፍል ስንት ነው?	0. መደበኛ ያልሆነ ትምህርት ቤት ከሆነ _____ (“X” ያስቀምጡ) 1. -----ክፍል	
111	የእርስዎ ባለቤት (እንደ ባልና ሚስት አብረው የሚኖሩት ወንድ) ቀለል ያሉ ጽሁፎችን በሚናገሩት ቋንቋ ማንበብና መጻፍ ይችላሉ?	1. አዎ 0. የለም ☐	ካሉ ወደ 113 ላገቡ ብቻ]
112	የመጨረሻ ያጠናቀቁት ክፍል ስንት ነው?	0 መደበኛ ባልሆነ ትምህርት ቤት ከሆነ----- (“X”ን ያስቀምጡ) 1. -----ክፍል	
113	በአሁኑ ወቅት የእርስዎ ዋነኛ የስራ አይነት ምንድን ነው?	1. ግብርና 2. የመነግስት ሰራተኛ 3. የግል ተቃጣሪ 4. እደጥበብተኛ 5. የቀን ሰራተኛ 6. የቤት እመቤት 7. ነጋዴ 8. ተማሪ 9 ሌላ ይግለጹ-----	
114	የባለቤትዎት (እንደ ባልና ሚስት አብረው የሚኖሩት ወንድ) ዋነኛ የስራ አይነት ምንድን ነው?	1. ግብርና 2. የመነግስት ሰራተኛ 3. የግል ተቃጣሪ 4. እደጥበብተኛ 5. የቀን ሰራተኛ 6. ነጋዴ 7. ዘበኛ 8. የቤት እመቤት 9. ተማሪ	ካሉ ወደ 113 ላገቡ ብቻ]

		9 ሌላ ካለ ይግለጹ	
115	በአጠቃላይ የቤተሰብዎ ቋሚ አባላት ብዛት ስንት ነው?	-----	
116	ለቤትዎ አስቤዛ/ ወጭ ወሳኔ የሚወስነው ማነው?	1 እኔ እራሴ 2 ባለቤቴ 3 የቤተሰቡ ታላላቆች 4 በጋራ 9 ሌላ ይግለጹ-----	
117	ጠቅላላ የወር ገቢዎ በአማካኝ በወር ሲሰላ ስንት ይሆናል(በአይነት የተገለፁ ገቢዎችን በወቅቱ የገበያ ዋጋ ተሰልቶ ይመዝገብ)	-----በር	

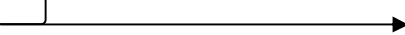
ክፍል ሁለት. ከነፍሰ ጡርነትና፣ ከወሊድ ጋር ተያያዢ የሆኑ ጉዳዮች መጠይቅ

ተ.ቁ	መጠይቆች	ምላሽ	ወደ ተ.ቁ
201	በመጀመሪያ ሲያገቡ ወይም ከወንድ ጋር እነደ ባልና ሚስት ሲኖሩ እድሜዎ ስንት ነበር?	-----አመት	
202	የመጀመሪያ እርግዝናዎን ሲያረግዙ እድሜዎ ስንት ነበር?	-----አመት	
203	የመጀመሪያ ልጅዎን ሲወልዱ እድሜዎ ስንት ነበር?	-----አመት	
204	ከእርስዎ ጋር የሚኖሩ ስንት ወንድና ሴት ልጆች አለዎት?	1 የወንድ ልጆች ብዛት----- 2 የሴት ልጆች ብዛት-----	
205	በህይወት ያሉ ነገር ግን ከእርስዎ ጋር የማይኖሩ ወንድና ሴት ልጆችዎ ብዛት ስንት ነው?	1 ሌላ ቦታ ያሉ የወንድ ልጆች ብዛት--- 2 ሌላ ቦታ ያሉ የሴት ልጆች ብዛት-----	
206	በአጠቃላይ ከተወለዱት ልጆች መካከል ስንት ልጆች ሙተዉበዎታል?	1 ወንድ----- 3. ጠቅላላ ድምር----- 2 ሴት-----	
207	በህይወት ዘመንዎ በአጠቃላይ ምን ያክል ልጆች ወልደዋል?.	1 ወንድ----- 3. ጠቅላላ ድምር----- 2 ሴት-----	
208	በቅረብ ባጋጠመዎት እርግዝና ወቅት የቅደመ ወሊድ ከትትል አድርገዉ ነበር?	1 አዎ 0 የለም ☐ 	ካሉ ወደ 211 ይለፉ

209	ለጥያቄ መልስዎ አዎ ከሆነ፣ በዚህ እርግዝናዎ ወቅት ለምን ያህል ጊዜ ለእረጉዞች የሚደርግ ምርመራን አግኝተዋል?	1. የጊዜ ብዛት----- 99. የለም ☐		ካሉ ወደ 211
210	በዚህ እርግዝናዎ ወቅት ለመጀመሪያ ጊዜ የቅድመ ወሊድ ምርመራ ሲያገኙ የስንት ወር እርጉዝ ነበሩ ?	1. -----ወር 99 አላስታውስም ☐		ካሉ ወደ 212 ይለፉ
211	ማን ነው ምርመራውን ያደረገለዎ ?	1. ሀኪም 2. ጤና መኮነን 3. አዋላጅ ነርስ/ነርስ 4. ጤና አክስቴንሽን ስራተኛ 9 ሌሎች ካሉ ይጥቀሱ-----		
212	በዚህ አንድ አመት ውስጥ የተወለደውን ልጅ የት ነበር የወለዱት?	1. በራሴ ቤት 2. በሌላ ቤት 3. ሆስፒታል 4. ጤና ጣቢያ 5. በግል ክሊኒክ 9 ሌላ (ይጠቀስ)-----		ካሉ ወደ 213 ይለፉ
213	መልሱ ቤት ከሆነ የጤና ድርጅት ያልመረጡበት ምክንያት ምንድን ነው? (ከአንድ በላይ መልስ ይቻላል)	1. ጤና ድርጅቱ ሩቅ ስለሆነ 2. ክፍያው ወድ ስለሆነ 3. ጤና ተቋሙ ብዙ ጊዜ ስለማይከፈት 4. መኖሪያ ቤት ስወልድ ምችት ስለሚሰማኝ 5. የልምድ አዋላጆች በቅርብ ስላሉ 6. ከዚህ በፊት በጤና ተቋማት ስዎልድ ችግር ስላጋጠመኝ 7. ሴት የጤና ባለሙያ በጤና ድርጅቱ ስለሌለ 8. የቤተሰቦቼ ምርጫ ስለሆነ 9. ሌላ ካለ (ይጠቀስ)-----		
214	በጤና ተቋም የወለዱ ከሆነ በጤና ተቋም መውለድ ለምን መረጡ? (ከአንድ በላይ መልስ ይቻላል)	1. ጎጂ ድርጊቶችን ለማስወገድ (ሆድን ማሸት፣ ባህላዊ መዳህኒት መጠቀም) 2. በጤና ተቋም መውለዴ የተሻለ ጤና ለእኔና ለልጄ እንደሚኖረኝ በማመኔ 3. ለመኖሪያ ቤቴ ቅርብ ስለሆነ 4. በመኖሪያ ቤት በመውለዴ ችግር ስላጋጠመኝ 5. በጤና ተቋም እንድወልድ ተመክሬ ስለነበር		

		6. በምጥ ጊዜ የእናቶችን ድካም ስለሚቀንስ 7. የእናቶችን ከወሊድ በኋላ ህመም ለመቀነስ 9 ሌላ(ይጠቀስ)-----	
215	የመጨረሻ ልጅዎትን ማን ነበር ያወለደዎት?	1. በሰለጠነ የጤና ባለሙያ(ዶክተር፣ ጤና መኮንን፣ ነርስ) 2. በጤና ክስቴንሽን ባለሙያ 3. በልምድ አዋላጅ 9 ሌላ ይጠቀስ-----	
216	በምን መልኩ ነበር የወለዱት?	1. በማህጸኔ በኩል ያለ ምንም መሳሪያ 2. በማህጸኔ በኩል በማዋለጃ መሳሪያ ድጋፍ 3. በሆዴ በኩል ቀዶ ጥገና ተደርጎለገኝ 4. በትክክል አላስታወሰም	
217	ከመጨረሻዎ እርግዝና፣ ምጥ፣ እንዲሁም ወሊድ ጋር ተያይዞ የተከሰተ ችግር ነበር ?	1 አዎ 0. የለም ☐ 	ካሉ ወደ 219 ይለፉ
218	ለጥያቄ ቁጥር “216” መልስዎ አዎ ከሆነ በእርግዝና ጊዜ የሚያጋጥሙ ችግሮችን ይጥቀሱ? (በራሳቸው መናገር ካልቻሉ በማወጣጣት ያጠናክሩ)(ከአንድ በላይ መልስ መስጠጥ ይቻላል)	1. በማህፀን ደም መፍሰስ 2. የእግርና የፊት እብጠት 3. ከባድ የራስ ምታት 4. የእይታ ችግር 5. የፅንሰ እንቅስቃሴ መጥፋት 6. ከባድ የሆድ ህመም 7. የክብደት መጨመር 8. ከባድ ትኩሳት 9. ሌላ ካለ(ይጠቀስ)-----	
219	ለችግሮች መፍትሄ ምን ነበር የወሰዱት?	1. ወደ ጤና ተቋም ሄድኩ 2. የልምድ አዋላጅ አማካርኩ 3. የባህል መዳህኒት ተጠቀምኩ 4. ምንም እርምጃ አለወሰድሁም 9 ሌላ ካለ ይገለፅ-----	

ክፍል ሶስት፤ እናቶች ስለ ሰለጠነ ባለሙያ አገልግሎት ያላቸው እውቀትና ግንዛቤ

ተ.ቁ	መጠይቆች	ምላሽ	ወደ ተ.ቁ
301	ከእርግዝና ጋር ተያይዘው የሚመጡ ችግሮች ያወቃሉ?	1. አዎ 0 የለም ☐ 	ካሉ ወደ 303 ይሂዱ

302	ለተራ ቁጥር “301” መልስዎ አዎ ከሆነ ችግሮች ምን ምን ናቸው? (ከአንድ በላይ መልስ ማክበብ ይቻላል)	1. ከእርግዝና ጋር የተያያዙ ችግሮች 2. የፅንሰ በሆድ ውስጥ መጥፋት 3. የእናቶች ሞት 9 ሌላ(ይጥቀሱ)-----	
303	አደገኛ የእርግዝና ምልክቶች የሚባሉንን ያውቃሉ?	1. አዎ 0 የለም ☐	ካሉ ወደ 305 ይለፉ
304	ለጥያቄ ቁጥር “303” መልስዎ አዎ ከሆነ ማን ማን ናቸው?(ከአንድ በላይ መልስ ማክበብ ይቻላል)	1. በማህፀኔ ደም መፍሰስ 2. የእግር እብጠጥ 3. ከባድ የራስ ምታት 4. የእይታ ችግር 5. የፅንሰ እንቅስቃሴ መጥፋት 6. የተለየ የሰውነት እቅስቃሴ(ኮንቨልዝን) 7. ከባድ የሁድ ህመም 8. የክብደት መጨመር 9. ከባድ ትኩሳት 9 ሌላ (ይጠቀስ)-----	
305	በባለፈው እርግዝናዎ ወቅት ስለቅድመወሊድ ዝግጅት መኖሩንና በወሊድ ወቅት ስለሚጋጥሙ ውስብስብ ችግሮች ሊከሰቱ እንደሚችሉ ያወቁ ነበር?	1. አዎ 0. የለም ☐	ካሉ ወደ 307 ይለፉ
306	ለጥያቄ ቁጥር “305” መልስዎ አዎ ከሆነ ከዝግጅቶችና ከችግሮች መካከል የትኞቹ ናቸው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. የመወለጃ ቦታ የመምረጥ 2. ለወሊድ ሚያስፈልጉ ቁሳቁሶችን ማዘጋጀት 3. የሚያዋለልደኝን ባለሙያ መለየት 4. አደገኛ ምልክቶችን ማወቅ 5. በወሊድ የተሻለ አገልግሎት የሚሰጡ የጤና ተቋማትን መለየት 6. በጉዳዩ የሚወስን ሰዉ ማመቻቸት 7. የመገናኛና የመጓጓዣ ዘዴዎችን ማስተካከል 8. የመጠባበቂያ ገንዘብ ማስቀመጥ 9. ደም የሚለግስ ሰዉ ማዘጋጀት 9 ሌላ ካለ ይጠቀስ-----	
307	አደገኛ የምጥ ምልክቶችን ያውቃሉ?`	1. አዎ 0 የለም ☐	ካሉ ወደ 309 ይለፉ

308	ለጥያቄዎ ቁጥር “307” መለስዎ አዎ ከሆነ ምልክቶች እነማን ናቸው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. የምጥ ከ12 ሰዓት በላይ መዘግየት 2. ያለጊዜው የእንሰሽርት ዉሃ መፍሰስ 3. ትክክል ያልሆነ የፅንሰ አመጣጥ 4. ማንቀጥቀጥ እንድሚጥል በሽታ ማድረግ 5. ደም መፍሰስ 6. የእንግዴ ልጅ ከአንድ ሰዓት በላይ መዘግየት 7. የደም ግፊት መጨመር 8. የምጥ ህመም ማቆም	
ከዚህ ቀጥሎ ላሉ ሃሳቦች መስማማት አለመስማማትዎን እንዲገልፁልኝ እፈልጋለሁ፡፡ አማራጭ መልሶችም፡ በጣም አልስማማም፣አልስማማም፣ እረግጠኛ አይደለሁም፣እስማማለሁ፣በጣም እስማማለሁ በማለት ይመልሱ፡፡			
309	በእርግጠኛነት ብዙዎችን በምጥ ጊዜ የሚከሰቱ ችግሮችን መከላከልና ማከም ይቻላል እላለሁ ብዬ አስባለሁ፡፡	1. በጣም አልስማማም 2. አልስማማም 3. እርግጠኛ አይደለሁም 4. እስማማለሁ 5. በጣም እስማማለሁ	
310	ማንኛውም ነፍሰጡር እናቶች ከወሊድ ጋር የተያያዘ የጤና ችግር ሊጋጥማቸው ይችላል ብዬ እገምታለሁ፡፡	1 በጣም አልስማማም 2 አልስማማም 3 እርግጠኛ አይደለሁም 4 እስማማለሁ 5 በጣም እስማማለሁ	
311	እደማንኛውም እረጉዝ ሴት በወሊድ ጊዜ ምክኒያት ለሚመጡ የጤና ችግሮች የተጋለጥሁ ነኝ ብዬ አምናለሁ፡፡	1. በጣም አልስማማም 2. አልስማማም 3. እርግጠኛ አይደለሁም 4. እስማማለሁ 5. በጣም እስማማለሁ	
312	በወሊድ ምክኒያት የሚመጡ የጤና ችግሮች በእኔና በልጄ ጤና ላይ አስከፊ ውጤትን ሊያሰከትሉ ይችላሉ ብዬ አስባለሁ፡፡	1 በጣም አልስማማም 2 አልስማማም 3 እርግጠኛ አይደለሁም 4 እስማማለሁ 5 በጣም እስማማለሁ	
313	በወሊድ ጊዜ በሰለጠነ ባለሙያ የታገዘች እናት ለራሷ ና ለተወለደዉ ህፃን የተሸለ የጤና ሁኔታ ይኖራታል ብዬ እገምታለሁ፡፡	1 በጣም አልስማማም 2 እስማማለሁ 3 እርግጠኛ አይደለሁም	

		4 እስማማለሁ 5 በጣም እስማማለሁ	
314	በጤና ተቋም ያሉ ባለሙያዎች የወሊድ ችግሮችን ለመለየት ለማከምና ከአቅማቸው በላይ ከሆነ ለመላክ ብቁ ናቸው	1. በጣም አልስማማም 2. አልስማማም 3. እርግጠኛ አይደለሁም 4. እስማማለሁ 5. በጣም እስማማለሁ	
315	በአቅራቢያዎ ያሉ ጤና ተቋማት ለወሊድ አገልግሎት የሚወልዱ በቂ መሳሪያዎችና ቁሳቁሶችን አሏቸው::	1. በጣም አልስማማም 2. አልስማማም 3. እርግጠኛ አይደለሁም 4. እስማማለሁ 5. በጣም እስማማለሁ	
316	ምንም የጤና ችግር ያላጋጠማት ነፍሰጡር እናት ቤት መወለድ አለባት::	1. በጣም አልስማማም 2. አልስማማም 3. እርግጠኛ አይደለሁም 4. እስማማለሁ 5. በጣም እስማማለሁ	

ክፍል አራት:-የጤና አገልግሎት አጠቃቀም መጠይቅ

401	በቀበሌዎ ቀረብ ያለ የጤና ጠቋም አለ ?	1. አዎ 0. የለም ☐	ካሉ ወደ 405 ይለፉ
402	ለተራ ቁጥር “401” መልስዎ አዎ ከሆነ ምን ያህል ይርቃል?	-----ቀን-----ሰዓት-----ደቂቃ	
403	ምን አይነት ጤና ተቋም ነው ያለዉ በአካባቢዎ የሚገኘው?	1. ጤና ኬላ 2. ክሊኒክ(የግል) 3. ጤና ጣቢያ 4. ሆስፒታል 9 ሌላ (ይጠቀስ)-----	
404	በጤና ድረጅቱ ምን ምን አይነት የጤና አገልግሎት ይሰጣል?	1. ቅድመ ወሊድ ክትትል 2. የወሊድ አገልግሎት 3. ድህረ ወሊድ አገልግሎት	

		4. ክትባት 5. የቤተሰብ ምጣኔ አገልግሎት 6. የፈጠረ ህክምና 9 ሌሎችን ይጥቀሱ-----	
405	በጤና ተቋማት ውስጥ ወልድኛ ያወቃሉ?	1. አዎ 0 የለም ☐ →	ወደ 409 ይለፉ
406	ለተራ ቁጥር “405” መልስዎ አዎ ከሆነ፤ ክፍያ ክፍለዋል ወይስ በነፃ ነዉ ያገኙት?	1. በነፃ 2. በክፍያ 3. አላስታወስም ☐ →	ካሉ ወደ 409 ይለፉ
407	በክፍያዉ ላይ ምን አስተያየት አለዎት?	1. ረካሽ ነዉ 2. መካከለኛ ነዉ 3. ዉድ ነዉ 4. አስተያየት የለኝም	
408	ለመከፈል አቅም ነበረዎት;	1. አዎ 0 የለም	
409	የጤና ባለሙያዎች በምጥ ላይ ላሉት እናት አመለካከታቸዉ እንዴት ነዉ?	1. በጣም ጥሩ አይደለም 2. ጥሩ አይደለም 3. መካከለኛ ነዉ 4. ጥሩ ነዉ 5. በጣም ጥሩ ነዉ	
410	ስለ ጤና ተቋም መወለድ ጥቅም ከዚህ በፊት መረጃዎችን ለመጀመሪያ ጊዜ ሰምተዉ ያወቃሉ?	1. አዎ 0. የለም ☐ →	ካሉ ወደ 501 ይሂዱ
411	መልስዎ አዎ ከሆነ ለመጀመሪያ ጊዜ መረጃዉን ከየት ሰሙ?	1. ከጤና ባለሙያዎች 2. ከጓደኛ፣ 3. ከጎረቤት 4. ከሪዲዮ፣ ከቴሌቪዥን 9 ሌላ ይገለፁ-----	

ከፍል አምስት. ከህብረሰቡ ጋር የተያያዙ ችግሮች(የቤተሰብ ና የማህበረሰቡ እዉቀትና ግንዛቤ)

ተ.ቁ	መጠይቆች	ምላሽ	ወደ ተ.ቁ
501	በወሊድ ጊዜ የጤና ባለሙያዎች በጤና ተቋማት ውስጥ የሚሰጡትን አገልግሎት በተመለከተ የባለቤትዎ አመለካከት ምን ይመስላል?	1. በጣም ጥሩ አይደለም 2. ጥሩ አይደለም 3. መካከለኛ ነዉ 4. ጥሩ ነዉ 5. በጣም ጥሩ ነዉ	
502	የባለቤቱዎ አመለካከት አሉታዊ ከሆነ ዋና ዋናዎቹ ምክንያቶች ምንድን ናቸዉ?(ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ብዙ ጊዜ ስለሚጨርሱ 2. ዋጋዉ ዉድ ስለሆነ 3. ባህላዊ ልምዶችን ማከናዎን ስለአልቻሉሁኝ (ቡና ማፍላትና ሌሎችም...) 4. የጤና ባለሙያዎች መጥፎ ስነምግባር 9 ሌላ ካለ ይገለፅ-----	
503	የቅርብ የቤተሰብ አባልዎ በማን ቢዋለዱ ይመርጣሉ?	1. የሰለጠነ ባለሙያ 2. በልምድ አዋላጅ 3. በጤና ኤክስቴንሽን ሰራተኛ 9 ሌላ ካለ ይገለፅ-----	
504	በጤና ተቋም የማዋለድ አገልግሎቱን የሚሰጡ ባለሙያዎች በህብረተሰቡ የተወደዱና የተከበሩ ናቸዉ?	1. አዎ 0 የለም ☐	ካሉ ወደ 507 ይለፉ
505	በምጥ ጊዜ የሚጠቀሙት ባህላዊ መዳሀኒት አለ?	1. አዎ 0. የለም ☐	ካሉ ወደ 507 የለፉ
506	ለተራ ቁጥር “505” መልስዎ አዎ ከሆነ ምክንያቱ ምንድን ነዉ?	1. ምጡን ለማፋጠን 2. ዉስብስብ ችግሮችን ለመከላከል 3. ህመሙን ለመቀነስ 9 ሌላ ካለ ይጥቀሱ-----	
507	እርሰዎ የጤና ክትትል ለማድረግ ገንዘብ ቢያስፈልግዎ ከማን ያገኛሉ	1. እኔ በቂ ገንዘብ አለኝ 2. ከቤተሰባችን 3. ከዘመዳ ወዳጅ 4. ከጋራችን 9 ሌላ ካለ ይጠቀሱ-----	

ስለነበረን ቆይታ በጣም አመሰግንዎታለሁ !!!

12.3 Annex Three: Focus Group Discussion Guide English Version Questionnaire

i. Information Sheet

Good morning or Good afternoon good participants. My name is Mulunesh Alemayehu, who is graduate student of Public Health at the School of Public Health in Addis Ababa University. The reason why I am here today is to discuss and understand the main barriers in the utilization of skilled birth attendance in Ankasha Guagusa Woreda. The information which I will get from you will be used to guide maternal health service delivery in the Woreda and beyond.

Your answers will be kept confidential. Everyone in the group will be given a chance to discuss on the issue under caption; feel free to talk but avoid repeating what has been already said. You should be aware that there is no wrong or right answer in this discussion. Your opinions are highly important and required for informing policy makers and programmers in the health sector. On the other hand, if you are not interested to participate, we can discontinue any time.

It is difficult to record all important information's obtained from your discussion with in short period of time. Hence, to listen and record again from what was discussed; I want to use Tape recorder. So, would you give me a permission to use tape recorder? Be sure your voice will be deleted and your personal information's not included during and after study report.

Thank you! Finally I will read your consent, to confirm your interest to participate.

ii. Consent Form

I hope, you, interviewees understand the aim of my study: Hence, in order to make a decision to participate in the research as follows.

1. Yes

2. No

Guiding Questions for Focused Group Discussant

Profiles of Discussants: - Age_____ Sex _____ Occupation_____

Kebele_____ Educational Status _____

1. What are your main health related problems in the area?
2. What are main health problems for mothers in the area?
3. What are some of the problems women will encounter during pregnancy?
4. What are some of the problems women will encounter during child birth?
5. What are cultural practices that have been held during pregnancy in the area?
6. What are some of the barriers that discourage your community not to use health facility delivery (economy, incompetence of providers, etc.)?
7. What do you routinely practice in your household after delivery?
8. What are some of the misunderstandings related to child birth in the area?
9. What are the barriers related to health delivery system?
10. What is providers' attitude towards labouring mother? Competence and skill of providers?
11. What are the beliefs, myths and misconception that are inhibit to use skilled delivery attendant during delivery in your community?
12. Do you thing starting of traditional practices in health facility improve the use of SBA?
13. Can you tell me an example of religion related beliefs and misconceptions that make mothers not to use SBA in this community?
14. Who should decide about your health care service? Why?

Thank You!!

12.4 አባሪ አራት፡ በተወሰነ ጉዳዮች ላይ በቡድን ለሚወያዩ ተወያዮች በአማረኛ የተተረጎመ መሪ መጠይቅ ሀ. የመረጃ ቅጽ

እንደምን አድራችሁ/ዋላችሁ ወድ ተሳታፊዎች ስሜ ሙሉኝ አለማየሁ ይባላል፤ በአዲስ አበባ ዩንቨርሲቲ ውስጥ በሚገኘው የህብረተሰብ ጤና ትምህርት ቤት የህብረተሰብ ጤና ተመራቂ ተማሪ ነኝ። እዚህ የመጣሁበት ዋናው ምክንያት እዚህ ወረዳ ብዙ እናቶች በሰለጠነ ባለሙያ እንዳይወልዱ የሚከለክሉአቸውን እንቅፋቶች እናንተን አሳትፌ ዋናና አስፈላጊ ናቸው የተባሉ መረጃዎችን ለማግኘት የተገኙትንም መረጃዎች ጉልበትና የበለጠ እይታ እንዲኖራቸው ለሚመለከተው ሁሉ ለማሳወቅ ነው። እናንተ የምተሰጡኝ መልስ ሚስጥራዊነቱ የተጠበቀ ነው።

ማንኛውም ተሳታፊ በነጻነት መናገር ይችላል ነገር ግን የተባሉትን ነገሮች ባይደጋግሙ መልካም ነው። እያንዳንዱ የምትናገሩት ሀሳብ በጣም ጠቃሚና አስፈላጊ ነች። ሁሉም የመትሰጡኝ ሀሳብ ግን ተክክል ወይም ስህተት ነው ማለት አይደለም፤ ለማለት የተፈለገው የመስላችሁን መናገር ትችላላችሁ ማለት ነው ። በሌላ መልኩ መሳተፍ ካልፈለጋችሁ በፈለጋችሁት ጊዜ ማቆም/ማስቆም ትችላላችሁ።

አመሰግናለሁ! በመጨረሻም ለመሳተፍ እርግጠኛ ከሆናችሁ የስምምነቱን ቅጽ አነብላችኋለሁ።

ለ. ስምምነት ቅጽ

የጥናቱ አላማ አሁን ገበቶቼችኋል ብዬ እገምታሁ ይህም በጥናቱ ለመሳተፍ ያላችሁን ፍላጎት ያረጋግጣል። ስለዚህ በዚህ ጥናት ላይ ለመሳተፍ ፍቃደኛ ናችሁ?

- 1. አዎ
- 2. የለም

በቡድን ተወያዮች መሪ መጠይቆች

የተወያዮቻች አጭር ታሪክ:-

እድሜ _____ ያታ _____ ስራ _____ ቀበሌ _____

የትምህረት ደረጃ _____

1. በእናንተ አካባቢ ጤና ነክ አበይ ችግሮች ምን ምን ናቸው?
2. በዚህ አካባቢ ለእናቶች ዋነኛ የጤና ችግር እነማን ናቸው?
3. እናቶች ከእርግዝና ጋር በተያያዘ ምንምን ችግሮች ያጋጥማቸዋል?
4. ከወሊድ ጋር በተያያዘ እናቶች ከሚጋጥሟቸው ችግሮች መካከል ዋና ዋናቸውን ጥቀሱ?
5. ቤት መወለድና ጤና ተቋም መወለድ ልዩነት አለው ብለው ያስባሉ? ካሰቡ ልዩነቶች እነማን ናቸው?
6. ከባህላዊ ልምዶች ውስጥ ነፍሰጡር እናቶችን የሰለጠነ ባለሙያ እንዳይጠቀሙ የሚያደርጉ እንቅፋቶች ምን ምን ናቸው ?
7. በምጥ የተያዙ እናቶች ከቤት በወሊድ ጊዜ የሚፈጽቸው ባህላዊ ልማዶች ብትዘረዝሩለኝ?
8. በእናንተ አካባቢ እናቶችን ወደ ጤና ተቋም እንዳይጠቀሙ ከሚከለክሏቸው እንቅፋቶች መካከል ጥቂቶቹን ጥቀሱልኝ (ከኢኮኖሚው፤ ከጤና ተቋም ፤ ከጤና ባለሙያ ብቃት አንፃር ሌሎችም ካሉ መጥቀስ ይቻላል)
9. በምጥ ጊዜ ቤት ውስጥ በተለምዶ ምን ምን ይደረጋል?
10. በአካባቢያችሁ ከወሊድ ጋር በተያያዘ የሚነገሩ የተሳሳተ ግንዛቤና አመለካከቶች ምን ምን ናቸው?
11. እናቶች በወሊድ ጊዜ የሰለጠነ ባለሙያን እንዳይጠቀሙ ከጤና ተቋም ጋር የተያያዙ እንቅፋቶች እነማን ናቸው(ለምሳሌ ፤ የጤና ባለሙያው በምጥ ካለች እናት ጋር ያለው አመለካከት፤ ብቃት ና ሌሎችም)
12. እናቶች በወሊድ ጊዜ የሰለጠነ ባለሙያ እንዳይጠቀሙ የሚያደርጓቸው እምነቶች፤ አሉባልታዎች ና የተሳሳተ ግንዛቤዎች ምን ናቸው?
13. በወሊድ ጊዜ ቤት ውስጥ በዘልማድ የምንከወናቸው ስራዎች በጤና ተቋም ቢጀመሩ ለውጥ ያመጣሉ ብላችሁ ትገምታላችሁ? እንዴት?
14. እናቶች የሰለጠነ ባለሙያ እንዳይጠቀሙ ከሀይማኖት ጋር ተያያዢ ከሆኑት እምነቶችና፤ የተሳሳቱ ግንዛቤዎችን ብትዘረዝሩለኝ?
15. ለመሆኑ እናቶች የጤና አገልግሎት ለማግኘት ቢፈልጉ አገልግሎቱን ለማግኘት ወሳኔ የሚሰጠው ማን ነው ? ለምን?

ሰለአዳመጣችሁኝ በጣም አመሰግናለሁ!

12.5 Annex Five: In-Depth Interview Guide English Questionnaire

a. Information Sheet

Good morning/Good afternoon dear participant. My name is Mulunesh Alemayehu, who is graduate student of Public Health at the School of Public Health in Addis Ababa University. The reason why I am here today is to discuss and understand the main barriers in the utilization of skilled birth attendance in Ankasha Guagusa Woreda. The information which I will get from you will be used to guide maternal health service delivery in the Woreda and beyond. Your answers will be kept confidential. Feel free to talk you should be aware that. On the other hand, if you are not interested to participate, we can discontinue any time.

Thank you. Finally I will read your consent, to confirm your interest to participate.

b. Consent Form

I hope, you understand the objectives of my study. So that, Are you willing to participate in this study?

1. Yes

2. No

Guiding Questions for In-Depth Interview

Personal Profile: -

1. Age_____
2. sex _____
3. Occupation _____
4. Education status_____
5. Kebele_____
6. What do you think is the level of skilled birth attendance in the area?
7. Why is it low?
8. What are the myths associated with skilled birth attendance in the area?
9. What are the misunderstanding associated to skilled birth attendance in the area?
10. What is the role of religion on skilled birth attendance utilization in the area?
11. What is the influence of culture and tradition on skilled birth attendance utilization in the area?
12. How do you rate the role of TBAs to deter/enhance utilization of skilled birth attendance in the area?
13. What are health system related barriers not to utilize skilled birth attendance in the area?
14. What are access related barriers that deter utilization of skilled birth attendance in the area?
15. What is women's autonomy related barriers deterring utilization of skilled birth attendance in the area?

Thank you!!!

12.6 አባሪ 6፡ በተናጥል ተሳታፊዎች ጋር የሚካሄድ ጠለቅ ያለ/ዋና መጠይቅ

ሀ. የመረጃ ቅጽ

እንደምን አደሩ/ዋሉ. ስሜ ሙሉንሽ አለማየሁ ይባላል፤ በአዲስ አበባ ዩንቨርሲቲ ውስጥ በሚገኘው የህብረተሰብ ጤና ትምህርት ቤት የህብረተሰብ ጤና ተመራቂ ተማሪ ነኝ።እዚህ የመጣሁበት ዋናው ምክንያት እዚህ ወረዳ ብዙ እናቶች በሰለጠነ ባለሙያ እነዳይወልዱ የሚከለከሉአቸውን እነቅፋቶችን እርስዎን አሳትፌ ዋናና አስፈላጊ ናቸው የተባሉ መረጃዎችን ለማግኘት የተገኙትንም መረጃዎች ጉልበትና የበለጠ እይታ እነዲኖራቸው ለሚመለከተው ሁሉ ለማሳወቅ ነው። በቃለ መጠይቁ ጊዜ ስምዎትን መጻፍ አይጠበቅበዎትም።እርስዎ የሚሰጡኝ መልስ ሚስጥራዊነቱ የተጠበቀ ነው።ማንኛውም በነጻነት መናገር ይችላል በሌላ መልኩ መሳተፍ ካልፈለጉ በፈለጉት ጊዜ ማቆም ይችላሉ ።

አመሰግናለሁ! በመጨረሻም ለመሳተፍ እርግጠኛ ከሆኑ የስምምነቱን ቅጽ አኑበለዎታለሁ ።

ለ. የስምምነት ቅጽ

የጥናቱ አላማ አሁን ገብቶዎታል ብዬ እገምታሁ. ስለዚህ በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ነዎት?

1. አዎ

2. የለም

በጥልቀት ለሚጠየቁ ተሳታፊዎች መሪ መጠይቆች

የተወያዩ አጭር ታሪክ

1. እድሜ _____
2. ፆታ _____
3. ስራ _____
4. የትምህርት ደረጃ _____
5. ቀበሌ _____
6. በእናንተ አካባቢ የሰለጠነ ባለሙያ አጠቃቀም ምን ይመስላል?
7. ለምን ዝቅ አለ?
8. ከሰለጠነ ባለሙያ አጠቃቀም ጋር በተያያዘ የተሳሳቱ አባባሎች እነማን ናቸው?
9. ከሰለጠነ ባለሙያ አጠቃቀም ጋር ተያያዘ የተሳሳቱ አመለካከቶችን ቢዘረዝሩለኝ?
10. ሃይማኖት ከጤና ተቋም የወሊድ አገልግሎት አጠቃቀም ጋር ምን ግንኙነት አለው ?
11. ከባህልና ወጎዎች ውስጥ በቀጥታ ሆነ በተዘዋዋሪ በእናቶች ላይ በጤና ተቋም እነዳይወልዱ ተፅዕኖ የሚያድረጉ ነገሮችን ቢዘረዝሩለኝ?
12. የልምድ አዋላጆች ስራ እናቶች በሰለጠነ ባለሙያ ድጋፍ እነዳይወልዱ ምን ያህል ይደገፋል ወይም እክል ይሆናል?
13. ከጤና ተቋም ጋር ተያያዘ እናቶች የሰለጠነ የወሊድ አገልግሎቱን እንዳያገኙ ያገዱት እንቅፋቶች እነማን ናቸው?
14. ከአቅርቦት ጋር ተያያዘ እናቶች በሰለጠነ ባለሙያ ድጋፍ እንዳይወልዱ የሚያደርጉ ምክኒያቶች ብትዘረዝሩለኝ ?
15. ከሴቶች መብት ጋር ተያያዘ የሰለጠነ ባለሙያ በሚፈልጉበት ጊዜ እንዳያገኙ መሰናክሎች ምን ምን ናቸው?

አመሰግናለሁ!

DECLARATION

I, the undersigned, MPH student declare that this thesis is my original work in partial fulfilment of master of degree program and had not been done before for 1st degree and above in this and other university and all sources of materials used for this thesis have been duly acknowledged.

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